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## **The lawfulness of gender reassignment surgery**

Penney Lewis\*

### **Abstract**

In the common law world, both the medical and legal professions initially considered gender reassignment surgery to be unlawful when first practised and discussed in the first half of the twentieth century. While most medical procedures are covered by the medical exception to the law governing serious offences against the person, many doctors and the lawyers they consulted doubted that this exception applied to gender reassignment surgery. In this article I trace the differing and changing interpretations of the medical exception as applied to gender reassignment surgery, and the shift towards legal acceptance in the two common law jurisdictions which led the way in both performing gender reassignment surgery and debating its legality, the United States and the United Kingdom. Although this shift occurred without formal legal intervention through either legislation or judicial decision (for example on a test case), inferences of legality drawn from related civil law decisions bolstered the legal acceptance of gender reassignment surgery.

By increasing the suffering of patients and potential patients, the criminal law played both an important and primarily malign role prior to the eventual public, professional and legal acceptance of GRS. A real threat of criminal prosecution

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inhibited doctors from proceeding, distorted diagnoses and affected the kinds of procedures performed. After-care was expanded and manipulated to avoid the risk of prosecution or the appearance of unlawful surgery. By contrast, civil and administrative law played a more positive albeit indirect role in interpreting the medical exception and its application to gender reassignment surgery.

PREPRINT MANUSCRIPT

## Introduction

In common law jurisdictions, in the absence of specific criminal offences,<sup>1</sup> medical practice is regulated by the criminal law in two main ways.<sup>2</sup> First, by the law governing serious offences against the person, which includes aggravated assault,<sup>3</sup> assault causing actual bodily harm or grievous bodily harm (often reworded as a form of serious assault), and wounding.<sup>4</sup> Second, by the crime of maim or mayhem,<sup>5</sup> which is a common law crime in some jurisdictions, including England and Wales,<sup>6</sup> and a statutory offence in others, including Canada<sup>7</sup> and most American states.<sup>8</sup> Either at common law or in statute, a medical exception exists which takes most medical treatment outside of both of these strands of the criminal law.<sup>9</sup>

In this article I begin by sketching the contours of the medical exception and explaining how and why the medical and legal professions initially viewed

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<sup>1</sup> For example, offences preventing or restricting access to abortion. See generally, MA Glendon, *Abortion and Divorce in Western Law* (Harvard University Press 1987) 10-62.

<sup>2</sup> If death is caused, other offences may also be relevant including homicide, manslaughter, murder (eg in euthanasia cases) and assisted suicide.

<sup>3</sup> In the United States, see American Law Institute, *Model Penal Code and Commentaries: (Official Draft and Revised Comments): With Text of Model Penal Code as Adopted at the 1962 Annual Meeting of the American Law Institute at Washington, D.C., May 24, 1962* (1980), § 211(2). In Canada, see Criminal Code, Rsc 1985, C C-46, s 268.

<sup>4</sup> In England and Wales, see Offences against the Person Act (Oapa), ss 18, 20, 47.

<sup>5</sup> The two words are equivalent. *State v Johnson* 58 Ohio St 417, 423 (1898, Ohio Supreme Court).

<sup>6</sup> *Wright's Case* (1604) 1 CoLit 127a, 127b; JF Stephen, *Digest of the Criminal Law* (FH Thomas 1878) 145-146; *Bravery v Bravery* [1954] 1 WLR 1169, 1180 (CA), Denning LJ, dissenting. In 1994, Lord Mustill, dissenting in *Brown* [1994] 1 AC 212, 262 (HL), considered the common law crime of maim to be "obsolete" although it has "not been expressly abolished" (PDG Skegg, *Law, Ethics and Medicine* (Clarendon Press 1984) 43).

<sup>7</sup> Maim is now incorporated within the crime of aggravated assault. Criminal Code (n 3) s 268.

<sup>8</sup> *Kitchens v State* 7 SE 209 (1888, Ga) (on the application of the statutory crime of mayhem to female genitalia); *State v Bass* 255 NC 42, 120 SE 2d 580 (1961, NC SC) (defendant doctor was criminally liable as accessory before the fact to mayhem for anaesthetizing hand of consenting victim who had hand cut off in pursuit of insurance fraud). See JR Monaghan, 'Consent as Defense to Charge of Mayhem' (1962) 86 ALR2d 268; ER Milhizer, 'Maiming as a Criminal Offense under Military Law' (1991) *Army Lawyer* 5; WR LaFave, 'Mayhem' (2015) 2 *Substantive Criminal Law* § 16.15.

<sup>9</sup> Stephen, *Digest* (n 6) 144, art 204, n 1. A more extensive examination of the medical exception and its relationship to new and controversial medical procedures is found in P Lewis, 'The Medical Exception' (2012) 65 CLP 355.

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gender reassignment surgery (GRS) as falling outside it, focusing primarily on the two common law jurisdictions which led the way in both performing GRS and debating its legality, the United States and the United Kingdom. I then trace the differing and changing interpretations of the medical exception as applied to GRS from the first procedures in the early twentieth century, the shift towards legal acceptance in the 1960s and the under-explored role of inferences of legality drawn from related civil law decisions in the 1970s. I conclude by assessing the impact of this period of legal uncertainty.

### **The medical exception in the context of GRS**

In order to qualify for the medical exception, two elements must be present. First, the patient's consent is required, although some substitute for consent will suffice when the patient is unable to consent. This substitute may take the form of consent from another person in a prescribed relationship to the patient,<sup>10</sup> or it may be entirely separate from consent, taking the form of a justification such as necessity or best interests.<sup>11</sup> Given its focus on GRS, this article will only consider patients who are able to provide a valid consent.

Second, some form of public policy justification is required.<sup>12</sup> The requirement of a public policy justification is often expressed by asking whether the patient *can* validly consent,<sup>13</sup> or asserting that the patient *cannot* validly consent.<sup>14</sup> To make

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<sup>10</sup> See, eg, Crimes Act 1961, s 61A (NZ); American Law Institute, *Model Penal Code* (n 3) § 3.08(4)(b).

<sup>11</sup> See, eg, *Brown* (n 6) 266.

<sup>12</sup> See, eg, G Hughes, 'Two Views on Consent in the Criminal Law' (1963) 26 MLR 233, 237.

<sup>13</sup> See, eg, G Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber 1958) 102.

<sup>14</sup> See, eg, DK Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (1971) 56 Cornell L Rev 963, 988-989.

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clearer the need for a public policy justification, one should rather ask whether the patient's consent is consistent with public policy.<sup>15</sup>

Consensus over the terminology used for the public policy justification, and over its content, is notable by its absence. The different versions of this public policy justification focus variously on the patient, the public, and the medical profession.

#### Patient-focused public policy justifications

Patient-focused justifications mandate that the procedure be intended to benefit the patient's health or be therapeutic for the patient. Some versions of this type of public policy justification impose a requirement that the performance of the procedure be "reasonable",<sup>16</sup> but others do not.<sup>17</sup> To avoid problems with unsuccessful procedures, the focus is on the doctor's intention to benefit the patient rather than actual benefit.<sup>18</sup> For example, the American Model Penal Code contains an exception for "a doctor or other therapist" who uses force "for the purpose of administering a recognized form of treatment that the actor believes to be adapted to promoting the physical or mental health of the patient".<sup>19</sup>

In *Corbett v. Corbett*, the earliest English legal case to touch on the lawfulness of GRS, Ormrod J applied a broad patient-focused public policy justification to conclude rather opaquely that:

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<sup>15</sup> SD Pattinson, *Medical Law and Ethics* (2nd edn, Sweet and Maxwell 2009) [4.6].

<sup>16</sup> See, eg, Criminal Bill Commission, *Report of the Royal Commission Appointed to Consider the Law Relating to Indictable Offences* (Cmd 2345, 1878-1879); Criminal Code (n 3) s 45; Crimes Act 1961 (n 10) s 61; Criminal Code (Queensland), s 282; Criminal Code (Western Australia), s 259.

<sup>17</sup> See, eg, *Corbett v Corbett* [1971] 2 P 83 (1970, HC), discussed in the text accompanying n 20.

<sup>18</sup> In the context of GRS, see *Doe v State, Dept of Public Welfare* 257 NW 2d 816, 821 (1977, Minn Supreme Court) (rejecting requirement that applicant for public funding demonstrate conclusively that GRS would be successful).

<sup>19</sup> American Law Institute, *Model Penal Code* (n 3) §§ 2.11(2), 3.08(4).

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There is obviously room for differences of opinion on the ethical aspects of such [gender reassignment] operations but, if they are undertaken for genuine therapeutic purposes, it is a matter for the decision of the patient and the doctors concerned in his case.<sup>20</sup>

Of course accepting that a procedure such as GRS *could* be justified using a patient-focused public policy justification does not mean that all GRS is so justifiable—the therapeutic nature of the procedure will need to be established in each case.<sup>21</sup> The American prosecutor Stan Twardy identified some cases where

surgery was offered on demand without any attempt to determine the mental stability of the patient, [or] where the surgeon acted with total disregard of accepted screening practices within the surgical and psychiatric professions... In some such cases, [a] prosecutor would have no difficulty in convincing [a] jury that the defendant was not interested in the patient's welfare and did not act in the patient's best interest, but acted merely for his own financial gain.<sup>22</sup>

#### Public-focused public policy justifications

Public-focused justifications vary in specificity, although they are generally broader than a patient-focused justification, ranging from the relatively narrow "just cause or excuse"<sup>23</sup> or "lawful purpose"<sup>24</sup> to the broader "public interest".<sup>25</sup> Such justifications are often used when a third-party beneficiary or obvious societal benefit is present.<sup>26</sup>

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<sup>20</sup> *Corbett v Corbett* (n 17) 99. In this case the marriage between Arthur Corbett and April Ashley, a male to female transsexual, was nullified or declared void on the grounds that Ashley was "not a woman for the purposes of marriage but is a biological male and has been so since birth." *ibid* 106.

<sup>21</sup> In the context of GRS, see, eg, *Doe v State* (n 18) 820-821.

<sup>22</sup> S Twardy, 'Medicolegal Aspects of Transsexualism' (1980) 26 *Medical Trial Technique Quarterly* 249, 295-296.

<sup>23</sup> *Bravery* (n 6) 1180.

<sup>24</sup> See, eg, Crimes Act 1961 (n 10) s 61A; RE Ross and GB McClure (eds), *A Treatise on Crimes and Misdemeanors [Russell on Crimes]*, vol 1 (8th edn, Stevens 1923) 847.

<sup>25</sup> See, eg, Criminal Bill Commission, *Report* (n 16) s 159; *Bravery* (n 6) 1175, 1180; *Attorney General's Reference (No 6 of 1980)* [1981] QB 715, 719 (CA) (Lord Lane CJ); P Skegg, 'Medical Procedures and the Crime of Battery' [1974] *Crim LR* 693, 696 (discussing the difference between the "just cause or excuse" approach and the "injurious to the public interest" approach).

<sup>26</sup> For example live organ donation, contraceptive sterilisation or non-therapeutic research.

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In the context of the procedures involved in GRS, members of the legal profession rarely used public-focused public policy justifications in support of GRS.<sup>27</sup> Lawyers and judges did occasionally use the language of the public-focused justification to express the lack of such a justification. One such example is found in the English case of *Cowburn*. A prisoner who had been convicted of sexual offences had consented to castration. The Court of Criminal Appeal refused to declare the operation lawful on the grounds that the question was not before the court.<sup>28</sup> Considering both the facts of *Cowburn* and the example of a male to female (MTF) transsexual seeking GRS, Thomas James concluded in 1969 that:

It would seem most doubtful whether, in England today, the facts of *R. v. Cowburn* could provide a *just cause* for the operation. Indeed, orchidectomy [castration] in any circumstances would seem unjustifiable in the eyes of the law in England, having regard to the present understanding of the subject.<sup>29</sup>

#### Professionally-focused public policy justifications

Professionally-focused public policy justifications include “*proper* medical treatment”<sup>30</sup> and “*reasonable* surgical interference”.<sup>31</sup> The use of adjectives such as “proper”, “reasonable” and “necessary” suggests some role for a court in

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<sup>27</sup> Unless the terms of a statutory medical exception reflect this form of public policy justification. For example, Skegg and Patterson argue that the statutory medical exception in the Crimes Act 1961 (n 10) s 61A permitting operations “for a lawful purpose” can now be applied to GRS. PDG Skegg, R Paterson and J Manning, *Medical Law in New Zealand* (Thomson Brookers 2006) [5.3.4(2)] and see below, n 216.

<sup>28</sup> G Williams, 'Consent and Public Policy' [1962] Crim LR 74, 159; Skegg, *Law, Ethics and Medicine* (n 6) 45. On *Cowburn*, see also, JDJ Havard, 'R v. Cowburn' [1959] Crim LR 554; 'Cowburn' [1959] Crim LR 590; *R v. Cowburn* The Times, 12 May 1959 (Court of Criminal Appeal); EM Wellwood, 'Medicine and the Law' (1959) 273 The Lancet 1090.

<sup>29</sup> TE James, 'Legal Issues of Transsexualism in England' in R Green and J Money (eds), *Transsexualism and Sex Reassignment* (The Johns Hopkins University Press 1969) 447 [emphasis added].

<sup>30</sup> See, eg, *Airedale NHS Trust v Bland* [1993] AC 789, 891 (HL); *Brown* (n 6) 266, 231, 245, 276; GH Gordon, *The Criminal Law of Scotland* (W Green & Son 1967) 774-775; Skegg, Paterson and Manning, *Medical Law in New Zealand* (n 27) [5.3.4(2)].

<sup>31</sup> See, eg, *A-G's Reference (No 6 of 1980)* (n 25) 719 (“as needed in the public interest”); *Brown* (n 6) 245 (“reasonable surgery”) or 242 (“necessary surgery”).



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evaluating medical practice. An even more professionally-focused justification simply reflects "good",<sup>32</sup> "accepted" or "recognized"<sup>33</sup> medical practice, on the grounds that the "[c]ontrols exercised by the medical profession itself should be accepted as sufficient."<sup>34</sup> How a particular medical practice becomes "accepted" or "recognised" is unclear.<sup>35</sup>

Early on, doctors and lawyers who applied a professionally-focused public policy justification to GRS usually did so in order to exclude it from the medical exception. In 1953, Alfred C. Kinsey wrote that GRS was "beyond acceptable medical practice".<sup>36</sup> In 1962, the Journal of the American Medical Association's Legal Department advised an Illinois physician who had been approached by a "transvestite" seeking castration and penectomy that the patient's consent "would not afford any defense if it were found that performance of the operations in the circumstances of the case were contrary to good medical practice in the community."<sup>37</sup>

### **GRS outside the medical exception**

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<sup>32</sup> See, eg, *Brown* (n 6) 258-259.

<sup>33</sup> See, eg, American Law Institute, *Model Penal Code* (n 3) § 3.08(4); RP Kouri, *Certain Legal Aspects of Modern Medicine (Sex Reassignment and Sterilization)* (Institute of Comparative Law, McGill University 1975) 75.

<sup>34</sup> G Williams, *Textbook of Criminal Law* (2nd edn, Sweet & Maxwell 1983) 590. See also, B Starkman, 'A Defence to Criminal Responsibility for Performing Surgical Operations: Section 45 of the Criminal Code' (1981) 26 McGill LJ 1048, 1055. For a critical view of this approach, see P Alldridge, 'Consent to Medical and Surgical Treatment—the Law Commission's Recommendations' (1996) 4 Medical L Rev 129, 137-138, 139, commenting on Law Commission of England and Wales, *Consent and Offences against the Person* (CP 134, 1994).

<sup>35</sup> Starkman, 'A Defence to Criminal Responsibility for Performing Surgical Operations' (n 34) 1055. See the Editor's Note on the first page of the article.

<sup>36</sup> J Meyerowitz, 'Sex Research at the Borders of Gender: Transvestites, Transsexuals, and Alfred C. Kinsey' (2001) 75 Bulletin of the History of Medicine 72, 88.

<sup>37</sup> RP Bergen, 'Questions and Answers: Transvestism Surgery' (1962) 182 JAMA 885, 888.

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Beginning in the early twentieth century, GRS was practised first on animals and then on "transvestites" by the 1920s and 1930s.<sup>38</sup> Transsexualism, "defined in part by the request for surgical sex change, did not appear as a medical category until the late 1940s and early 1950s."<sup>39</sup> Leading endocrinologists including Harry Benjamin<sup>40</sup> and Christian Hamburger<sup>41</sup> viewed the demand for GRS from both men and women as signifying an as-yet undiscovered hormonal or other physiological abnormality which could be treated using existing plastic surgery techniques.<sup>42</sup> Worldwide, medical opinion on the appropriateness and ethics of GRS was polarised with little consensus on issues of diagnosis and treatment. As one American psychiatrist wrote of both MTF and female to male (FTM) transsexuals, these differences of clinical opinion were exacerbated because "the situation of the person requesting a change of sex ... involve[s] sex and ha[s] been [a] tabooed topic[] and ... give[s] rise to strong personal sentiment and convictions, resulting in reactions and counter-reactions, with moral and religious overtones."<sup>43</sup> The patients and their demands were not the only source of ethical controversy. GRS required plastic and especially cosmetic surgery.

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<sup>38</sup> JJ Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Harvard University Press 2002) 2, 29-35.

<sup>39</sup> *ibid* 2. See also, M Dillon, *Self: A Study in Ethics and Endocrinology* (Heinemann 1946) 60-65.

<sup>40</sup> See K Schilt, 'Harry Benjamin', *Encyclopædia Britannica* (Encyclopædia Britannica Inc 2015); J Meyerowitz, 'Benjamin, Harry (B. 12 January 1885; D. 24 August 1986), Endocrinologist, Expert on Transsexuality, Advocate for Transsexuals.' in M Stein (ed), *Encyclopedia of Lesbian, Gay, Bisexual, and Transgender History in America*, vol 1 (Charles Scribner's Sons/Thomson/Gale 2004).

<sup>41</sup> See J Starup, 'Christian Hamburger' (1974) 75 *Acta Endocrinologica* 1.

<sup>42</sup> BL Hausman, *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (Duke University Press 1995) 46.

<sup>43</sup> IB Pauly, 'The Current Status of the Change of Sex Operation' (1968) 147 *The Journal of Nervous and Mental Disease* 460, 467. See also, 'Review of the Principles and Art of Plastic Surgery Sir Harold Gillies, C.B.E., F.R.C.S.; D. Ralph Millard, Jr., M.D. London: Butterworth. 1957. Pp. 652. £12 10s. (in Two Volumes).' (1958) 271 *The Lancet* 945, 946. A flavour of the early controversy can be gleaned from the responses to C Hamburger, GK Sturup and E Dahl-Iversen, 'Transvestism; Hormonal, Psychiatric, and Surgical Treatment' (1953) 152 *JAMA* 391 in which the authors recounted their experience of providing GRS in Denmark. See, eg, M Ostow, 'Transvestism' (1953) 152 *JAMA* 1553; GH Wiedeman, 'Transvestism' (1953) 152 *JAMA* 1167.

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Other physicians already viewed this branch of medicine with scepticism, raising concerns about poorly-trained, irresponsible charlatans exploiting vulnerable patients.<sup>44</sup> As Benjamin noted, "[t]he [early plastic] surgeons were bitterly criticized, were refused membership in medical societies, and were branded by some of their colleagues as quacks. And sex was not even involved then!"<sup>45</sup> In addition, many doctors had a "natural reluctance to remove healthy organs in the absence of somatic pathology."<sup>46</sup>

From a legal perspective, GRS was particularly problematic for two reasons. First, the law of maim or mayhem explicitly included castration. Second, none of the public policy justifications were readily available. In the absence of either professional or public consensus, debate raged over the patient-focused public policy justification. Strong views that the surgery was "mutilating" made it difficult to establish that the procedure benefitted rather than harmed patients.

#### Castration as maim or mayhem

The common law historically regarded castration as a maim or mayhem. Thus it was difficult to argue that the law of maim or mayhem did not apply to the MTF procedure (though as we shall see, one leading American commentator directly challenged this reading of the law of maim). In theory the medical exception could have been applied to procedures which would otherwise constitute maim or mayhem, most obviously if the procedure would save the patient's life or

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<sup>44</sup> Hausman, *Changing Sex* (n 42) 51-52, citing G Aufricht, 'The Development of Plastic Surgery in the United States' (1946) 1 *Plastic and Reconstructive Surgery* 3, 21.

<sup>45</sup> H Benjamin, 'Nature and Management of Transsexualism, with a Report on Thirty-One Operated Cases' (1964) 72 *Western Journal of Surgery, Obstetrics, and Gynecology* 105, 110.

<sup>46</sup> Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 60.

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prevent deterioration in their physical health.<sup>47</sup> However discussion of castration as maim or mayhem rarely progressed to any public policy justification. Instead, the legal debate raged over whether castration did or did not constitute maim or mayhem; the underlying assumption apparently being that this was determinative of its legality.<sup>48</sup> This made the threat of criminal prosecution extremely powerful, creating a significant chilling effect on the performance of GRS. This was particularly true in the USA,<sup>49</sup> where relatively recent and expansive<sup>50</sup> mayhem statutes made the threat of prosecution very real. Courts interpreted these statutes broadly; if they did not explicitly include female genitalia, judges inferred such an inclusion, making them potentially applicable to FTM procedures.<sup>51</sup> In contrast, in those jurisdictions where maim

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<sup>47</sup> J Miller and G Dean, 'Liability of Physicians for Sterilization Operations' (1930) 16 *American Bar Association Journal* 158, 158-159; Skegg, *Law, Ethics and Medicine* (n 6) 45; Monaghan, 'Consent as Defense to Charge of Mayhem' (n 8); Milhizer, 'Maiming as a Criminal Offense under Military Law' (n 8) 8.

<sup>48</sup> See, eg, K Walker and P Fletcher, *Sex and Society: A Psychological Study of Sexual Behaviour in a Competitive Culture* (Muller 1955) 195.

<sup>49</sup> Benjamin, 'Nature and Management of Transsexualism' (n 45) 110; H Benjamin, *The Transsexual Phenomenon* (Julian Press 1966) 142 (describing the law as "intimidat[ing] doctors"); R Green, 'Attitudes toward Transsexualism and Sex-Reassignment Procedures' in R Green and J Money (eds), *Transsexualism and Sex Reassignment* (The Johns Hopkins University Press 1969) 240; DW Meyers, 'Problems of Sex Determination and Alteration' (1968) 36 *Medico-Legal Journal* 174, 182; DW Hastings, 'Inauguration of a Research Project on Transsexualism in a University Medical Center' in R Green and J Money (eds), *Transsexualism and Sex Reassignment* (The Johns Hopkins University Press 1969) 243; RJ Tierney and TM O'Brien, 'You're a Good Man Charlotte Brown or What Now My Love?' (1968) 37 *Hennepin Lawyer* 4, 7; JP Holloway, 'Transsexuals - Their Legal Sex' (1968) 40 *University of Colorado L Rev* 282, 284; J Money and F Schwartz, 'Public Opinion and Social Issues in Transsexualism: A Case Study in Medical Sociology' in R Green and J Money (eds), *Transsexualism and Sex Reassignment* (The Johns Hopkins University Press 1969) 258; Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 467; DH Russell, 'The Sex-Conversion Controversy' (1968) 279 *The New England Journal of Medicine* 535, 536. In the United Kingdom, see PMF Bishop, 'Discussion' following the chapter by CN Armstrong, 'Transvestism' in D Robertson-Smith and WM Davidson (eds), *Symposium on Nuclear Sex* (Heinemann Medical Books 1958) 90.

<sup>50</sup> Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 74; RC Donnelly, 'Liability of Physician for Sterilization in Virginia' (1951) 78 *Virginia Medical Monthly* 24, 25; FV Harper, 'Sex and the Law' in CW Lloyd (ed), *Human Reproduction and Sexual Behaviour* (Henry Kimpton 1964) 517.

<sup>51</sup> See, eg, *Kitchens* (n 8); *Moore v State* 3 Pin 373 (1851, Wisc).

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remained a little-used common law offence, such as the UK, scholars more often disputed its continued relevance to medical practice.<sup>52</sup>

The principal source for the view that castration constituted maim appears to be Hawkins, *Pleas of the Crown*:

... such a Hurt of any Part of a Man's Body, whereby he Is rendered less able in Fighting, either to defend himself or annoy his Adversary, is properly Maim. And Therefore the cutting off, or disabling, or weakening a Man's Hand, or Finger, or striking out his Eye or Foretooth, or castrating him, are said to be Maims, but the cutting off his Ear, or Nose, etc., are not esteemed Maims, because they do not weaken, but only disfigure him.<sup>53</sup>

According to Hawkins, castration was a felony punishable by death.<sup>54</sup> Noting this, Stephen confirmed that "Castration is a maim."<sup>55</sup> Early American<sup>56</sup> and Canadian<sup>57</sup> writers agreed, advancing two reasons for this; both related to the Crown's interest in a strong military. First, castration "abates [a man's] courage" thus "render[ing] him the less able in fighting".<sup>58</sup> Second, "[t]here were obvious

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<sup>52</sup> 'The Legal Responsibility of the Surgeon' (1925) 205 *The Lancet* 931; LLM Minty, 'Unlawful Wounding: Will Consent Make It Legal?' (1956) 24 *Medico-Legal Journal* 54, 58-59; Skegg, *Law, Ethics and Medicine* (n 6) 43-44.

<sup>53</sup> W Hawkins, *Treatise of the Pleas of the Crown*, vol 1 (3rd edn, 1739) 111-112 [emphasis added]. See, eg, HW Smith, 'Antecedent Grounds of Liability in the Practice of Surgery' (1941-1942) 14 *Rocky Mountain L Rev* 233, 277, citing Hawkins.

<sup>54</sup> Hawkins, *Treatise of the Pleas of the Crown* (n 53) 112.

<sup>55</sup> Stephen, *Digest* (n 6) 145; WO Russell and CS Greaves, *A Treatise on Crimes and Misdemeanors*, vol 1 (3rd edn, Saunders and Benning 1843) 719-720.

<sup>56</sup> J Bouvier, *A Law Dictionary Adapted to the Constitution and Laws of the United States of America and of the Several States of the American Union with References to the Civil and Other Systems of Foreign Law* (5th edn, printed for the estate of John Bouvier 1855) 209; JP Bishop, *Commentaries on the Criminal Law* (3rd edn, Little, Brown, and Company 1865), vol 1 §§ 568, 957, 969, 974, citing *Commonwealth v Newell* 7 Mass 245 (1810, SJC); *Adams v Barrett* 5 Ga 404 (1848, SC); *Commonwealth v Lester* 2 Va Cas 198 (1820, General Court), also mentioning *The State v Absence* 4 Port 397 (1837, SC Ala) and *contra The State v Thompson* 30 Misso 470 (1860, SC); JW May, *The Law of Crimes* (Little, Brown, and Company 1881) § 180; WO Russell and CS Greaves, *A Treatise on Crimes and Misdemeanors*, vol 1 (7th edn, T & JW Johnson 1853) § 719.

<sup>57</sup> Prior to codification, the common law of maim in Canada included castration. GW Burbidge and JF Stephen, *A Digest of the Criminal Law of Canada (Crimes and Punishments) Founded by Permission on Sir James Fitzjames Stephen's Digest of the Criminal Law* (Carswell & Co 1890) 199.

<sup>58</sup> SW Blackstone, *Commentaries on the Laws of England*, vol 4 (16th edn, T Cadell and J Butterworth and Son 1825) 205. See also, F Pulton, *De Pace Regis Et Regni* (Printed by Adam Islip for the Companie of Stationers 1609), fol 15, s 59; *Russell on Crimes* (n 24) 810; James, 'Legal Issues of Transsexualism in England' (n 29) 447; Williams, *Textbook of Criminal Law* (n 34) 590. For an early American view, see Bishop, *Commentaries on the Criminal Law* (n 56) § 568.

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military objections to allowing a man to do or to undergo anything which disabled him from begetting sons."<sup>59</sup>

Lawyers first and rather mysteriously applied this conception of castration as maim to male sterilisation.<sup>60</sup> When doctors later began receiving requests for GRS, commentators across the common law world pointed out the applicability of the law of maim or mayhem to castration:

As such operations, entailing as they do castration, are illegal in this country [Great Britain] and in the United States, their search for a surgeon is very unlikely to be successful.<sup>61</sup>

In the United States, concerns grew within the medical profession about the lawfulness of GRS in the late 1940s and into the 1950s.<sup>62</sup> Harry Benjamin, one of the leading physicians treating transsexuals, wrote in 1953:

"Conversion operations" have mainly been performed in [continental] Europe because in the U.S.A. they are illegal ... The law offers no human or scientific understanding for the problem of the male transvestites ... If they qualify for a feminizing operation and can find a surgeon competent and willing to perform it, the law steps in and forbids the operation as "mayhem." This at least is the situation in the United States.<sup>63</sup>

Benjamin's colleague Alfred C. Kinsey agreed with this assessment of the unlawfulness of GRS.<sup>64</sup> In Canada, Keith Moore, a doctor, and Clifford Edwards, a

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<sup>59</sup> Department of Health (Great Britain), *Report of the Departmental Committee on Sterilisation* (Cmd 4485, 1934), [70]. This view of mayhem was also taken by Minty, 'Unlawful Wounding' (n 52) 58.

<sup>60</sup> Miller and Dean, 'Liability of Physicians for Sterilization Operations' (n 47) 158-159; J Ellison and others, *Sex Ethics. The Principles and Practice of Contraception, Abortion, and Sterilisation* (Baillie & Co 1934) 219.

<sup>61</sup> Walker and Fletcher, *Sex and Society* (n 48) 195. See also, James, 'Legal Issues of Transsexualism in England' (n 29) 447.

<sup>62</sup> Hamburger, Sturup and Dahl-Iversen, 'Transvestism; Hormonal, Psychiatric, and Surgical Treatment' (n 43) 395; Meyerowitz, *How Sex Changed* (n 38) 42-43.

<sup>63</sup> H Benjamin, 'Transvestism and Transsexualism' (1953) 7 *International Journal of Sexology* 12, 14. The following year, Benjamin described the operation as "supposedly illegal". H Benjamin, 'Transsexualism and Transvestism as Psychosomatic and Somatopsychic Syndromes' (1954) 8 *American Journal of Psychotherapy* 219, 229.

<sup>64</sup> Meyerowitz, 'Sex Research at the Borders of Gender' (n 36) 88-89.

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lawyer, published a similar conclusion in journals aimed at both medical and legal professionals:

What about the transvestite or sex deviate then? The medical profession in this country generally ... tends to regard such surgery, as for example castration, upon a normal anatomical person as illegal.<sup>65</sup>

However, one leading American legal commentator directly challenged the view that castration constituted maim, using a legally flawed though influential argument. Despite the significant historical evidence already described, and contemporaneous opinion to the contrary,<sup>66</sup> including the opinion of local District Attorneys and state Attorneys General consulted about the lawfulness of castration,<sup>67</sup> the American lawyer Robert Veit Sherwin argued that the offence of mayhem did not include castration.<sup>68</sup> Much of the contemporaneous opinion stemmed from an influential article by Miller and Dean published in the *American Bar Association Journal* in 1930:

such a[ sterilization] operation might result in liability for mayhem or maiming. This would be clearly true in case of castration because the effect of the operation is to change the entire physical character of the individual ... Although no case has been found at the common law where a physician was held criminally liable for performing a

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<sup>65</sup> CHC Edwards, 'Recent Developments Concerning the Criteria of Sex and Possible Legal Implications' (1959) 31 *Manitoba Bar News* 115, 126. See also, KL Moore and CHC Edwards, 'Medico-Legal Aspects of Intersexuality: Criteria of Sex: Part II' (1960) 83 *Canadian Medical Association Journal* 756, 759.

<sup>66</sup> See, eg, *People v Kopke* 376 Ill 171, 174 (1941, Supreme Court) and the sources cited in n 71.

<sup>67</sup> See nn 106-109 and accompanying text.

<sup>68</sup> RV Sherwin, 'The Legal Problem in Transvestism' (1954) 8 *American Journal of Psychotherapy* 243, 244. The British academic lawyer Glanville Williams also asserted the lawfulness of castration, but without specific consideration of the law of maim and its application:

The legality of castration (the de-sexing operation) is also in debate. Although no normal person would submit to such an operation, it may occasionally be recommended as the only way of obtaining relief from abnormalities in the sexual urge, and it is hard to suppose that in these cases) least, the judges would regard it as unlawful.

Williams, 'Consent and Public Policy' (n 28) 159. Unlike Sherwin, Williams' view did not influence medical practice, and his fellow legal academics were unconvinced. Even ten years later, the Canadian scholar Robert Kouri was "inclined to think that [Williams'] optimism is somewhat unfounded." Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 68. David Meyers also disagreed with Williams, describing his conclusion as "rather bold". DW Meyers, *The Human Body and the Law: A Medico-Legal Study* (Edinburgh University Press 1970) 53.

castration operation upon a person with his consent, nevertheless criminal liability would seem to be *certain* in such a case in view of the gist and scope of the crime of mayhem and the attitude of the law toward the effect of consent in such cases. Of course justification or excuse might appear from the facts of the particular case which would absolve the surgeon from criminal liability.<sup>69</sup>

Although Miller and Dean's conclusion that castration was unlawful because it would "change the entire physical character of the individual" was not derived from the historical sources they cited,<sup>70</sup> it was picked up by later commentators.<sup>71</sup>

Sherwin, like his friend Benjamin, was deeply frustrated by this use of mayhem:

Rarely has the law been used in such a ridiculous and unscientific fashion. The Mayhem Statute has no connection, even in its origin, with anything remotely related to the subject under discussion. It was a king's device in the days of yore to prevent his men from becoming useless as fighters in his army. He therefore made it a serious crime for a man to dismember in any way any limb or part of the body that would make him less able to fight.<sup>72</sup>

Sherwin explained the basis of his view in a separate article published in the same year:

Any part of the body needed by a soldier for fighting had a premium placed upon it by means of declaring it to be a severe crime if such a part were cut off. The cases very clearly indicate that such parts as an ear or a penis were not "limbs needed in the act of defending one's king" and thus not within the statute. Nevertheless, for lack of an appropriate law, the mayhem statute has been extended to include any willful disfigurings of the body.<sup>73</sup>

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<sup>69</sup> Miller and Dean, 'Liability of Physicians for Sterilization Operations' (n 47) 158-159 [emphasis added].

<sup>70</sup> J Bouvier and F Rawle, *Bouvier's Law Dictionary and Concise Encyclopedia*, vol 1 (8th edn, West Publishing Company 1914) 430; Hawkins, *Treatise of the Pleas of the Crown* (n 53) 107; JP Bishop, JM Zane and CFG Zollmann, *Commentaries on the Criminal Law. Bishop on Criminal Law* (9th edn, TH Flood and Co 1923) § 1001.

<sup>71</sup> See, eg, Smith, 'Antecedent Grounds of Liability in the Practice of Surgery' (n 53) 277 ("Castration so alters the personality and physical constitution that its performance, even with consent, would doubtless constitute the crime of mayhem under the common law."); Donnelly, 'Liability of Physician for Sterilization in Virginia' (n 50) 26; Harper, 'Sex and the Law' (n 50) 517.

<sup>72</sup> Sherwin, 'The Legal Problem in Transvestism' (n 68) 244.

<sup>73</sup> RV Sherwin, 'Sex Crime—a Failure of the Law' (1954) 12 Bar Bulletin New York County Lawyers Association 116, 117-118.



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In 1969, Sherwin repeated his views confusing castration with penectomy in a chapter in an important collection edited by Richard Green and John Money entitled *Transsexualism and Sex Reassignment*.<sup>74</sup>

Although Sherwin was correct in relation to ears,<sup>75</sup> his focus on the surgical removal of the penis—rather than on castration—was misleading. Whatever the authorities had to say about whether cutting off a penis constituted maim or mayhem,<sup>76</sup> they were unanimous that castration was a very serious act of maim or mayhem, originally carrying the death penalty, and subsequently the only form of the crime to be considered a felony.<sup>77</sup>

Nonetheless, Sherwin's view that castration did not fall within the crime of mayhem was picked up by influential psychiatrists in papers presented at the annual meetings of the American Psychiatric Association, published in leading psychiatric and legal journals and medical texts,<sup>78</sup> and in other chapters of

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<sup>74</sup> RV Sherwin, 'Legal Aspects of Male Transsexualism' in R Green and J Money (eds), *Transsexualism and Sex Reassignment* (The Johns Hopkins University Press 1969) 421.

<sup>75</sup> Hawkins, *Treatise of the Pleas of the Crown* (n 53) 111; Blackstone, *Commentaries* (n 58) 205. Although the position in relation to ears was altered by 37 Hen 8 C 6 1545. See Blackstone, *Commentaries* (n 58) 206-207.

<sup>76</sup> Many modern American mayhem or mayhem-replacement statutes include dismemberment which would cover penectomy. LaFave, 'Mayhem' (n 8) n 14, citing *Cole v State* 62 TexCrim 270 (1911, Ct Crim App).

<sup>77</sup> Hawkins, *Treatise of the Pleas of the Crown* (n 53) 111-112; Blackstone, *Commentaries* (n 58) 206. See also, Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 73; JP Holloway, 'Transsexuals – Some Further Legal Considerations' (1972) 5 Comparative and International Law Journal of South Africa 71, 74, discussing *State v Sheldon* 169 P 37 (1917, SC Mont). Castration continues to be regarded as mayhem in the USA. LaFave, 'Mayhem' (n 8) § 16.5(c).

<sup>78</sup> KM Bowman and B Engle, 'Medicolegal Aspects of Transvestism' (1957) 113 The American Journal of Psychiatry 583, 584 (although by 1960 Bowman and Engle were less convinced by Sherwin's argument that castration did not fall within the ambit of mayhem, citing only his admission that "*it is generally regarded as coming within the proscription of the mayhem statutes*" [emphasis added]. KM Bowman and B Engle, 'Sex Offenses: The Medical and Legal Implications of Sex Variations' (1960) 25 Law and Contemporary Problems 292, 307, citing Sherwin, 'The Legal Problem in Transvestism' (n 68); JL Hampson, 'Deviant Sexual Behavior: Homosexuality; Transvestism' in CW Lloyd (ed), *Human Reproduction and Sexual Behaviour* (Henry Kimpton 1964) 508; Benjamin, 'Nature and Management of Transsexualism' (n 49) 110. For a modern account which appears to accept Sherwin's argument, see D Rudacille, *The Riddle of Gender: Science, Activism, and Transgender Rights* (Pantheon Books 2005) 116.

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*Transsexualism and Sex Reassignment*.<sup>79</sup> At the very least, Sherwin's concerted campaign appears to have created confusion about the applicability of mayhem statutes to castration. Doubts about legality still remained though, as exemplified by the answer given to a question asked by a doctor approached to perform GRS in 1962 in the *Journal of the American Medical Association*.<sup>80</sup> The response from JAMA's Legal Department informed the doctor that he risked being charged with mayhem and advised him to obtain a legal opinion from the state attorney general "or a court ruling as to whether or not the operations would constitute a violation of criminal law."<sup>81</sup>

Despite Sherwin's efforts, the view that castration constituted maim or mayhem had a significant impact on medical practice, driving GRS underground or abroad. Alternatively, surgeons disguised castration as a more obviously therapeutic procedure, or avoided it by moving rather than removing the testicles. Key narratives influenced professional attitudes towards the lawfulness of GRS. In the next section I use two such linked narratives from the United Kingdom, and two separate narratives from the United States to illustrate these effects.

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<sup>79</sup> Money and Schwartz, 'Public Opinion and Social Issues in Transsexualism' (n 49) 258.

<sup>80</sup> See text accompanying n 37.

<sup>81</sup> Bergen, 'Questions and Answers: Transvestism Surgery' (n 37) 888. See also, N Lukianowicz, 'Survey of Various Aspects of Transvestism in the Light of Our Present Knowledge' (1959) 128 *The Journal of Nervous and Mental Disease* 36, 57; J Dukeminier, Jr., 'Supplying Organs for Transplantation' (1970) 68 *Michigan L Rev* 811, 853; Meyers, 'Problems of Sex Determination and Alteration' (n 49) 183; Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (n 13) 989 ("The existence of a mayhem statute should not be considered an absolute bar to the operation, but it would be advisable to consult with the local district attorney or seek an advisory opinion of the state attorney general before performing sex reassignment surgery.").

Narratives 1 and 2: Michael Dillon, Roberta Cowell and Harold Gillies

In the United Kingdom, GRS divided legal opinion when it first came to legal attention in the 1950s and 1960s. The influential psychiatrist Narcyz Lukianowicz suggested in *The Journal of Nervous and Mental Disease* that the fact that one such procedure had been performed in 1953 necessarily indicated its lawfulness.<sup>82</sup> The procedure to which Lukianowicz referred formed part of a narrative involving Michael Dillon, Roberta Cowell and the country's leading plastic and reconstructive surgeon, Harold Gillies.<sup>83</sup> Gillies thought that any procedure which benefitted the patient was justified:

My view of whether a cosmetic operation is justifiable is clear. If it is going to make a great difference to the patient in happiness, in social advancement, and particularly in a job, it is justified. If it gives real happiness, that is the most that any surgeon or medicine can give.<sup>84</sup>

Dillon (who had been born female as Laura) was a patient of Gillies who had met Cowell (who had been born male as Robert) following the publication of Dillon's book, *Self: A study in ethics and endocrinology* in 1946.<sup>85</sup> In *Self*, written while Dillon was transitioning, he argued for GRS:

there is, for these people, no recognized form of treatment other than that offered by the psychologists; for what the patient asks, namely, that his body be made to fit his mind, is refused him. This, according to the psychologists, would be mere mutilation and, since it leads to non-productivity, therefore useless ... Surely, where the mind cannot be made to fit the body, the body should be made to fit, approximately, at any rate to the mind, despite the prejudices of those

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<sup>82</sup> Lukianowicz, 'Survey of Various Aspects of Transvestism in the Light of Our Present Knowledge' (n 81) 57. For evidence of Lukianowicz's influence on medico-legal commentators, see Bowman and Engle, 'Sex Offenses: The Medical and Legal Implications of Sex Variations' (n 78) 307; Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (n 13) 989. For opinions to the contrary, see n 61.

<sup>83</sup> See R Battle, 'Gillies, Sir Harold Delf (1882–1960)', *Oxford Dictionary of National Biography* (rev edn, Oxford University Press 2004). For a theatrical glimpse of Gillies as a pioneer of reconstructive surgery during the First World War, see H Brenton, *Doctor Scroggy's War* (Nick Hern Books 2014).

<sup>84</sup> R Pound, *Gillies, Surgeon Extraordinary: A Biography* (M Joseph 1964) 123.

<sup>85</sup> Dillon, *Self* (n 39).

who have not suffered these things, yet to suffer which they so readily condemn others.<sup>86</sup>

Cowell had been taking hormones for some time and wanted her genitalia altered to correspond with her "female outlook".<sup>87</sup> Although Gillies had been willing to help Dillon by providing surgery<sup>88</sup> as he had done for other FTM transsexuals,<sup>89</sup> he was not prepared to run the risk of prosecution for maim and perform castrations on MTF transsexuals like Cowell.<sup>90</sup> Unable to find a doctor in England who would perform the castration, Cowell eventually convinced Dillon, now a medical student, to perform it, outside of a hospital, in secret.<sup>91</sup>

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<sup>86</sup> *ibid* 53.

<sup>87</sup> HD Gillies and DR Millard, *The Principles and Art of Plastic Surgery* (Little, Brown 1957) 385.

<sup>88</sup> Gillies described what he had done for Dillon in his textbook:

he came for plastic consultation and after due consideration the case was undertaken. ... The technical performances included the partial closing of the vaginal opening, the joining of the urethra to a new length of skin tube incorporated in a tube pedicle, and finally the insertion of cartilage in this new penis. It was presumed that any vaginal secretions that might arise would be voided down the urethra, as the junction between old and new urethrae was more by juxtaposition than suture. The clitoris, with its special nerve supply, was preserved and grafted at the dorsum of the penis near its root. A scrotum was constructed by a square flap from the pubic region including the mons pubis with its hair and fat. On bilateral pedicles it was lifted over the penis and suspended below to form the sac. Subsequently the pedicles were divided and draped more closely around the shaft of the penis. After minor initial difficulties no trouble has been experienced with urination. Provided thus with the new organ, the patient's life has been a social success; he has become an active and successful business man and is very anxious to have everything done that would make it justifiable for him to marry.

*ibid* 384. Dillon's "surgery to change his gender (13 operations between 1946 and 1949) is considered the first of the modern era because of its surgical sophistication and its early use of testosterone." M Roach, 'Girls Will Be Boys' *New York Times* (18 March 2007) <<http://www.nytimes.com/2007/03/18/books/review/Roach.t.html>> accessed 15 August 2013.

<sup>89</sup> L Hodgkinson, *Michael, Née Laura* (Columbus 1989), chapters 4 and 5. Caution was still exercised in such cases although the threat of prosecution was less acute. See text accompanying nn 129-131.

<sup>90</sup> P Kennedy, *The First Man-Made Man: The Story of Two Sex Changes, One Love Affair, and a Twentieth-Century Medical Revolution* (Bloomsbury Publishing 2008) 64.

<sup>91</sup> Cowell signed a waiver before Dillon performed the orchidectomy:

I, R.C. have, of my own free will asked and persuaded L.M.D., who I am aware is an unqualified man, a 5th year medical student, to perform an orchidectomy upon me. I am also aware that his operating experience has been confined solely to assisting at operations as a resident pupil in hospital and to one appendectomy in the presence of a surgeon and that he has neither seen nor practiced this particular operation. I desire that he be absolved from all responsibility in this operation, due to possible hemorrhage or sepsis, which I am desirous to undergo being fully aware that either might, per fortunam, be fatal.

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Once the MTF transsexual had undergone the orchidectomy, either outside the country or underground,<sup>92</sup> like Cowell, British surgeons were willing to provide after-care including the construction of a vagina.<sup>93</sup> Gillies (and his colleagues) undertook these procedures for Cowell, describing them in his textbook, *The Principles and Art of Plastic Surgery*.<sup>94</sup> It appears that Gillies knew that his patient Dillon had performed the orchidectomy on his new patient Cowell. In his textbook, Gillies described Cowell's testicles as "functionally embryonic" prior to their "removal abroad", which permitted him to conclude that "it might be argued that had the castration been performed in Great Britain the law of mayhem in reference to mutilation would not have applied", the underlying assumption being that had the testicles been healthy, their removal would have constituted maim.<sup>95</sup> Of course much of this was false. Gillies was likely trying to protect both himself and Dillon from any possible prosecution for maim, both by disguising the location and identity of the "surgeon", and by arguing that in any event the orchidectomy would not have constituted a maim even if performed in the UK. Cowell had not been castrated abroad, although many British and American transsexuals did travel to Mexico,<sup>96</sup> Morocco,<sup>97</sup> Japan,<sup>98</sup> the Netherlands,<sup>99</sup> France,<sup>100</sup> Italy,<sup>101</sup> or Scandinavia<sup>102</sup> for castration and other

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R Cowell, *Roberta Cowell's Story by Herself* (Hamilton & Co 1955); Kennedy, *The First Man-Made Man* (n 90) 91.

<sup>92</sup> Kennedy, *The First Man-Made Man* (n 90) 164-166.

<sup>93</sup> D King, *The Transvestite and the Transsexual: Public Categories and Private Identities* (Avebury 1993) 54, describing surgeons who were willing to "finish[] off" but "not begin[] an irreversible process."

<sup>94</sup> Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 385-386. This is discussed in more detail in the text accompanying nn 144-145.

<sup>95</sup> *ibid* 386. The testicles had been preserved in section, presumably by Dillon.

<sup>96</sup> Benjamin, *The Transsexual Phenomenon* (n 49) 118.

<sup>97</sup> H Benjamin, 'Clinical Aspects of Transsexualism in the Male and Female' (1964) 18 *American Journal of Psychotherapy* 458, 465. April Ashley and Jan Morris both went to Casablanca. See *Corbett v Corbett* (n 17) 99; J Morris, *Conundrum* (Faber 1974).

<sup>98</sup> Benjamin, *The Transsexual Phenomenon* (n 49) 118.

<sup>99</sup> *ibid*; King, *The Transvestite and the Transsexual* (n 93) 54.

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surgical procedures. Cowell's testicles were unlikely to have been "functionally embryonic" given that as a man, Robert Cowell had fathered two children and been a decorated fighter pilot who was physically examined before he was admitted into the Royal Air Force in 1941.<sup>103</sup> While the testicles were atrophied, this was likely due to the hormones Cowell had been taking for years prior to the orchidectomy.<sup>104</sup> Cowell's was not the only case in which doctors falsified medical records and publications to protect those involved from the threat of prosecution. "[I]n some cases it seems that the phrase 'castrated abroad' was a euphemism used to hide the identity of the surgeon concerned."<sup>105</sup>

### Narrative 3: Val Barry

Harry Benjamin's involvement in one particular potential surgical case had left him frustrated with the law of mayhem. In 1948, the Wisconsin state Attorney General's office advised a hospital contemplating performing GRS including castration on a patient known as "Val Barry" that such an operation would constitute mayhem.<sup>106</sup> In 1949 the then California Attorney General Edmund G. Brown provided similar advice to Benjamin in relation to the same patient.<sup>107</sup> In reply, Benjamin wrote to Brown:

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<sup>100</sup> Benjamin, *The Transsexual Phenomenon* (n 49) 118.

<sup>101</sup> *ibid.*

<sup>102</sup> *ibid.*; J Meyerowitz, 'Sex Change and the Popular Press: Historical Notes on Transsexuality in the United States, 1930–1955' (1998) 4 GLQ: A Journal of Lesbian and Gay Studies 159 (on Christine Jorgensen's surgery in Denmark and Lynn (or Val) Barry's surgery in Sweden). See also, Meyerowitz, *How Sex Changed* (n 38) chapter 2.

<sup>103</sup> Kennedy, *The First Man-Made Man* (n 90) 56.

<sup>104</sup> Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 385-386.

<sup>105</sup> King, *The Transvestite and the Transsexual* (n 93) 54. Many surgical interventions apparently went unrecorded or unreported. *ibid.* 60.

<sup>106</sup> Meyerowitz, *How Sex Changed* (n 38) 47. See also, Meyerowitz, 'Sex Research at the Borders of Gender' (n 63) 79. This may be the same case described in Sherwin, 'Sex Crime—a Failure of the Law' (n 73) 117. See also, Benjamin, *The Transsexual Phenomenon* (n 49) 142.

<sup>107</sup> Meyerowitz, *How Sex Changed* (n 38) 47.

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it is difficult to reconcile my common sense with the fact that statutes based on the requirements of English kings in the middle ages should still be valid ... I do not see how any surgeon anywhere in this country could possibly perform such operation.<sup>108</sup>

Even the lawyer Robert Veit Sherwin accepted that the prevailing legal advice from prosecutors would be to the effect that castration constituted mayhem:

there is hardly a district attorney in the country who would not inform a doctor that it would be illegal for the doctor to perform such an operation. When asked for proof of his statement, the District Attorney would point to the Mayhem Statute.<sup>109</sup>

In addition to advice from prosecutors "throughout the country",<sup>110</sup> lawyers advised surgeons against operating.<sup>111</sup> Although the advice given was not uniformly negative,<sup>112</sup> "[Brown's] opinion cast a pall, lasting for years, over efforts by U.S. transgender people to gain access to transsexual medical procedures in their own country."<sup>113</sup>

#### Narrative 4: Hedy Jo Starr

As in the United Kingdom, the law of mayhem affected American medical practice. One transsexual, Hedy Jo Star, described her face being covered with a sheet while she was examined by specialists who wished to remain anonymous because the planned procedure "was illegal under New York law". Although her surgeon was willing to proceed, and numerous specialists approved,

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<sup>108</sup> *ibid* 35. See also, Benjamin, *The Transsexual Phenomenon* (n 49) 142.

<sup>109</sup> Sherwin, 'The Legal Problem in Transvestism' (n 68) 243-244. Along similar lines, see Sherwin, 'Sex Crime—a Failure of the Law' (n 73) 117-118.

<sup>110</sup> JG Raymond, *The Transsexual Empire* (Women's Press 1980) 40.

<sup>111</sup> Benjamin, *The Transsexual Phenomenon* (n 49) 47. "Benjamin's friend Max Thorek, a renowned surgeon in Chicago, initially sympathetic, refused, *on his lawyer's advice*, to operate [on Val Barry]." Meyerowitz, *How Sex Changed* (n 38) 48 [emphasis added] and see also at 121 (advice from law professor based on legal "uncertainty").

<sup>112</sup> By 1962, a later attorney general of California (Stanley Mosk) advised another doctor (Robert Stoller) that "we have not, to my knowledge, ever contended that such an operation with sound medical justification and the consent of the transvestite, is illegal." Meyerowitz, *How Sex Changed* (n 38) 121. See also, RJ Stoller, 'A Biased View of 'Sex Transformation' Operations: An Editorial' (1969) 149 *The Journal of Nervous and Mental Disease* 312, 314.

<sup>113</sup> S Stryker, *Transgender History* (Seal Press 2008) 45.

the New York State Medical Society refused to grant permission for the surgery ... The decision of the society was based not on medical or scientific criteria, but on a fear of legal action. In New York State, as in almost every other civic jurisdiction in the United States, it was illegal to surgically remove a man's testicles.<sup>114</sup>

In Baltimore at Johns Hopkins, the doctors were also unwilling to perform the surgery for fear of the Maryland mayhem statute, writing to Star in 1959 that "there are numerous reasons from both your standpoint and from the standpoint of the surgeons involved that would suggest that the performance of this type of surgery might in actuality constitute mayhem ..."<sup>115</sup>

Alternatively, surgeons responded to the law of mayhem by modifying the surgical procedure so that it could no longer be described as castrative. Thus doubts about the legality of castration also influenced *how* surgical reassignments were performed. In his 1964 book *The Transsexual Phenomenon*, Benjamin observed that some surgeons would preserve the testicles invisibly, in order to avoid being "accused of a (possibly illegal) castration operation."<sup>116</sup> Elmer Belt, a California urologist who performed most of the procedures that took place in the United States in the 1950s<sup>117</sup> "thought it medically best to preserve the testicles and the hormones they produced,<sup>118</sup> and thereby managed to avoid whatever legal liability castration might potentially involve."<sup>119</sup> This practice also occurred in the United Kingdom.<sup>120</sup> The leading British surgeon

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<sup>114</sup> Rudacille, *The Riddle of Gender* (n 78) 116.

<sup>115</sup> *ibid* 117, quoting from HJ Star, *My Unique Change* (Novel Books, Incorporated 1965). Further legal and medical developments at Johns Hopkins are discussed in the text accompanying nn 190, 192-195.

<sup>116</sup> Benjamin, *The Transsexual Phenomenon* (n 49) 101.

<sup>117</sup> Stryker, *Transgender History* (n 113) 45.

<sup>118</sup> Benjamin cited this as another reason for retaining the testicles, "based on the theory that the testes in transsexual men may produce more estrogen than they do normally ... although they have as yet found no confirmation." Benjamin, *The Transsexual Phenomenon* (n 49) 100.

<sup>119</sup> "Belt used a procedure in which he preserved the testicles, pushing them through the inguinal ring out of the scrotum and into the abdomen." Meyerowitz, *How Sex Changed* (n 38) 146.

<sup>120</sup> King, *The Transvestite and the Transsexual* (n 93) 54.



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John Randell described this procedure as a "redistribution operation ... devised to avoid legal difficulties and the charge of mayhem."<sup>121</sup>

The impact of castration as maim or mayhem on the clinical practice of GRS

The view that castration constituted maim or mayhem, coupled with the failure to recognise that the medical exception might nonetheless be applicable to castration in the context of GRS resulted in a reluctance to perform it openly. Doctors restricted themselves to after-care or re-sited rather than removed the testicles. They employed subterfuge and concealment to avoid the label of GRS by ostensibly performing a procedure covered by the patient-focused public policy justification. The criminal law of maim or mayhem thereby shaped the clinical practice of GRS.

### **Interpreting the medical exception for GRS**

Doubts over the lawfulness of GRS were not however restricted to the threat of maim or mayhem associated with castration. More broadly, the applicability of the medical exception to any of the procedures involved in GRS was in doubt. In the next three sections, I examine further the role of the criminal law in shaping GRS through the prism of the three versions of the public policy justification focused on the patient, the medical profession and the public.

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<sup>121</sup> J Randell, 'Preoperative and Postoperative Status of Male and Female Transsexuals' in R Green and J Money (eds), *Transsexualism and Sex Reassignment* (The Johns Hopkins University Press 1969) 371.

Patient-focused public policy justification

In his oft-cited article *Psychopathia Transexualis*, the psychiatrist David O. Cauldwell recounted his response to an early request from a FTM transsexual for GRS:

it would be criminal for any surgeon to mutilate a pair of healthy breasts and it would be just as criminal for a surgeon to castrate a woman with no disease of the ovaries or related glands and without any condition wherein castration might be beneficial.<sup>122</sup>

Many other doctors also described such operations as “mutilating”<sup>123</sup> and agreed that they should not be undertaken.<sup>124</sup> Indeed Michael Dillon had echoed this language in his book *Self*, arguing in favour of patient autonomy: “Is it not for the individual to judge whether he should be ‘mutilated,’ experimented on or left alone?”<sup>125</sup> The very issue of whether the procedure caused a net harm was in dispute, meaning that the most common version of the medical exception’s public policy justification that focused on the patient might not be available.

Commentators argued that the patient-focused public policy justification was absent, on the grounds that any psychological benefit to the patient was outweighed by physical harm.<sup>126</sup> The legal commentator David Meyers described

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<sup>122</sup> DO Cauldwell, 'Psychopathia Transexualis' (1949) 16 *Sexology* 274, 278.

<sup>123</sup> A Correspondent, 'Sexual Deviation' (1960) 276 *The Lancet* 922. See also, DO Cauldwell, *Sex Transmutation—Can One's Sex Be Changed?: There's but a Thin Line between the Sexes, but the Would-Be Sex Transmutees Battle Forces More Stubborn Than the Genes* (Haldeman-Julius Publications 1951) 19, reprinted as DO Cauldwell, 'Sex Transmutation – Can One's Sex Be Changed? There's but a Thin Genetic Line between the Sexes, but the Would-Be Sex Transmutees Battle Forces More Stubborn Than the Genes' (2001) 5 *International Journal of Transgenderism*; KL Moore and CHC Edwards, 'Medico-Legal Aspects of Intersexuality: Criteria of Sex: Part I' (1960) 83 *Canadian Medical Association Journal* 709, 713; CW Socarides, 'The Desire for Sexual Transformation: A Psychiatric Evaluation of Transsexualism' (1969) 125 *The American Journal of Psychiatry* 1419, 1424; Dillon, *Self* (n 39) 53; Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 386.

<sup>124</sup> Editorial, 'Change of Sex' (1954) 1 *BMJ* 694; C Allen, 'Change of Sex' (1954) 1 *BMJ* 1040.

<sup>125</sup> Dillon, *Self* (n 39) 55.

<sup>126</sup> TB Smith, 'Law, Professional Ethics and the Human Body' (1959) *Scots Law Times (News)* 245, 247; James, 'Legal Issues of Transsexualism in England' (n 29) 449 (“Orchidectomy or mastectomy could be safely performed if for therapeutic purposes; but this would scarcely cover

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GRS as "a severe and 'unlawful' physical invasion ... deemed harmful to the ill-fated transsexual."<sup>127</sup> Doctors attempted to bring GRS within the patient-focused public policy justification by manipulating diagnoses, expanding the role of after-care, and focusing on the risk of harm to the patient if GRS were not provided.

#### Alternative diagnoses

As we have already seen for orchidectomy,<sup>128</sup> doctors manipulated diagnoses so that procedures appeared more obviously therapeutic. For Dillon, for example, Gillies originally used a diagnosis of acute hypospadias,<sup>129</sup> so that in his medical records Dillon appeared to be a man who required "a cosmetic repair of his penis."<sup>130</sup> One British surgeon performed hysterectomies on FTM transsexuals on the grounds that "if it is not going to be used, you might as well remove a potentially cancer-bearing organ."<sup>131</sup>

Doctors also used deliberately vague or misleading terms in hospital records in order to disguise the nature of the operations. Thus the condition of an MTF transsexual might be described vaguely as "genitalia" or more specifically (and truthfully if misleadingly) "congenital absence of vagina".<sup>132</sup> Gillies applied the

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cases involving change-of-sex operations in England at the present time"). A similar position was taken in 1971 by the New York State Board of Health which was of the view that "surgery for the transsexual is an experimental form of psychotherapy by which mutilating surgery is conducted on a person with the intent of setting hi[s] mind at ease". By refusing to permit the transsexual's new sex to be entered on his new birth certificate, the Board hoped to discourage GRS. *Hartin v Director of Bureau of Records* 347 NYS2d 515, 518 (1973, Supr Ct).

<sup>127</sup> Meyers, *The Human Body and the Law* (n 68) 54.

<sup>128</sup> See text accompanying n 95.

<sup>129</sup> A birth defect of the urethra in which the opening is abnormally placed.

<sup>130</sup> Kennedy, *The First Man-Made Man* (n 90) 71. A real case of hypospadias is found in Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 371-372.

<sup>131</sup> J Randell, 'Indications for Sex Reassignment Surgery' (1971) 1 *Archives of Sexual Behavior* 153, 161. Interestingly, Dillon did not have a hysterectomy, perhaps because no gynaecological surgeon could be found willing to perform the procedure. Hodgkinson, *Michael, Née Laura* (n 89) 93.

<sup>132</sup> King, *The Transvestite and the Transsexual* (n 93) 54.

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latter phrase to Roberta Cowell,<sup>133</sup> and also used "congenital absence of the penis with male outlook" for FTM surgeries, possibly including Michael Dillon.<sup>134</sup>

Some clinicians suggested that the category of "intersex" diagnoses, for which surgery including castration<sup>135</sup> was recognised as therapeutic and "good medical practice"—using the patient-focused and professionally-focused public policy justifications respectively—should be extended to include those seeking sex reassignment.<sup>136</sup> Patients (including Roberta Cowell)<sup>137</sup> also claimed to have been born with an intersex condition in order to convince their doctors that GRS was therapeutically indicated.<sup>138</sup>

#### Expanded role of "after-care"

The undertaking of surgical after-care following self-castration,<sup>139</sup> initial surgery abroad<sup>140</sup> or underground<sup>141</sup> is a relatively well-known feature of the

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<sup>133</sup> Roberta Cowell herself wrote that "[Gillies] told me that the operation for congenital absence of vagina was completed." Cowell, *Roberta Cowell's Story by Herself* (n 91) 106.

<sup>134</sup> Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 371; Hausman, *Changing Sex* (n 42) 207.

<sup>135</sup> E Reis, *Bodies in Doubt: An American History of Intersex* (Johns Hopkins University Press 2009) 48, 69, 77-78, 103, 112, 194.

<sup>136</sup> Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 370-371, discussed in King, *The Transvestite and the Transsexual* (n 93) 54-55; BL Hausman, 'Body, Technology, and Gender in Transsexual Autobiography' in S Stryker and S Whittle (eds), *The Transgender Studies Reader* (Routledge 2006) 342-344. See also, AP Cawadiaz, 'Change of Sex' (1954) 1 BMJ 876. See contra, Allen, 'Change of Sex' (n 124); Moore and Edwards, 'Medico-Legal Aspects of Intersexuality: Criteria of Sex: Part I' (n 123) 713; *Forbes-Sempill* (29 December 1967, Court of Session Outer House (Scotland)) (dispute over hereditary baronetcy resolved in favor of "hermaphrodite" who had had his birth records corrected). (Though commentators agree that Ewan Forbes-Sempill was a transsexual. See, eg, L-A Barnes, 'Gender Identity and Scottish Law: The Legal Response to Transsexuality' (2007) 11 Edinburgh L Rev 162.)

<sup>137</sup> Cowell, *Roberta Cowell's Story by Herself* (n 91), discussed in Kennedy, *The First Man-Made Man* (n 90) 56.

<sup>138</sup> Reis, *Bodies in Doubt* (n 135) 203, n 98. An example is described in Hausman, *Changing Sex* (n 42) 1-2.

<sup>139</sup> For example, the case of Caren Ecker described in Bowman and Engle, 'Medicolegal Aspects of Transvestism' (n 78) 587 and Meyerowitz, *How Sex Changed* (n 38) 145. Penotomy was performed after self-castration, in part due to fears that the patient "might again try self-emasculatation and harm himself more seriously." Bowman and Engle, 'Medicolegal Aspects of Transvestism' (n 78) 587.

<sup>140</sup> See King, *The Transvestite and the Transsexual* (n 93) 54 ("most patients ... went to Holland or France to be castrated, returning to Britain for plastic surgery"). For other surgical destinations,

development of GRS. In 1968, Robert J. Stoller, a leading gender researcher observed:

Almost no such procedures have been performed in the last few years in major American medical centers (with the exception of patients who had already gotten parts of the operation done somewhere else, or where the patient had already mutilated himself).<sup>142</sup>

Less well-known is the way in which the medical profession expanded and manipulated after-care to avoid the risk of prosecution or the appearance of unlawful surgery. Hormone treatment could be provided to a physically normal patient, resulting in changes to genitalia and secondary sexual characteristics which themselves could then be used to justify surgery on an "intersex" or otherwise "abnormal" patient.<sup>143</sup> Harold Gillies' discussion of Roberta Cowell's "functionally embryonic" testicles provides an example of this approach.<sup>144</sup> An excerpt from the uro-genital consultant's report on Cowell stated:

I feel that orchidectomy and hormone treatment have had such a marked effect on this patient that there now seems to be no alternative but to assist the completion of the metamorphosis. Apart from all the other circumstances and clinical facts, I feel justified in my opinion that the patient is now more female than male, by finding that both the prostate and seminal vesicles are practically non-existent. I am content that no active seminal secretion is being manufactured and that any prostatic tissue which may still exist is negligible. Therefore, considering all the circumstances, I think there is justification for operative treatment to assist metamorphosis, in

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see text accompanying nn 96-102. For examples of the after-care of individual patients, see Morris, *Conundrum* (n 97) 127; Meyerowitz, *How Sex Changed* (n 38) 145-146 (Annette Dolan).

<sup>141</sup> See Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 467 (drawing an analogy with after-care following backstreet abortion). For example, see the discussion of the after-care provided to Roberta Cowell, in the text accompanying nn 92-94, and Charlotte McLeod, described in Meyerowitz, *How Sex Changed* (n 38) 82. On "underground practitioners in the United States" in the 1950s, see also, *ibid* 150.

<sup>142</sup> RJ Stoller, *Sex and Gender: On the Development of Masculinity and Femininity* (Science House 1968) 250.

<sup>143</sup> On the use of the intersex diagnosis to justify GRS using the patient-focused public policy justification, see the text accompanying nn 135-138.

<sup>144</sup> See nn 94, 103-104 and accompanying text.

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spite of the vaguely possible danger that in 10 years or more the patient's female feelings may again change to the opposite sex.<sup>145</sup>

In the United Kingdom, King describes an interesting strategy used for a short period in the 1950s, with both medical and legal characteristics:

In some early cases after hormone treatment, the legal sex was changed<sup>146</sup> thus enabling plastic surgery to be justified as corrective. One doctor explained to the press that in [Roberta] Cowell's case the amended birth certificate was "in the nature of a working certificate to enable the plastic surgeons to carry out their operations" (Sunday Pictorial, March 14<sup>th</sup>, 1954). After [publicity surrounding] the Cowell case this ceased to be possible although it was still seen as desirable and attempts were still made to gain the approval of Somerset House [which then housed the General Register Office].<sup>147</sup> After a while the surgeons involved decided a legal change of name would be sufficient (interview).<sup>148</sup>

Psychological benefit and avoidance of harm

Alternative attempts to justify the procedures focused on emphasising the psychological benefits to the patient from surgery,<sup>149</sup> and/or the risk of harm associated with non-provision. As is already evident from some of the after-care cases,<sup>150</sup> this was not a theoretical risk; cases of suicide<sup>151</sup> and self-harm<sup>152</sup> did

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<sup>145</sup> Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 386. Gillies also described Dillon pre-operatively as having a "large clitoris and diminutive vagina", probably the result of hormone therapy. *ibid* 383.

<sup>146</sup> This was apparently then easy to do even prior to surgery, although only a small number of such cases are known. See Kennedy, *The First Man-Made Man* (n 90) 52, 87; Hamburger, Sturup and Dahl-Iversen, 'Transvestism; Hormonal, Psychiatric, and Surgical Treatment' (n 43) 393 (two British MTF transsexuals were "legally registered" as women "despite the presence of normal male genitals.")

<sup>147</sup> See, eg, Pound, *Gillies, Surgeon Extraordinary* (n 90) 244 for an example of such an attempt. Having changed her name to April Ashley by deed poll, the MTF transsexual in *Corbett v Corbett* also attempted unsuccessfully to change her legal sex after her surgery in Morocco ((n 17) 93).

<sup>148</sup> King, *The Transvestite and the Transsexual* (n 93) 53-54.

<sup>149</sup> Walker and Fletcher, *Sex and Society* (n 48) 199; Pound, *Gillies, Surgeon Extraordinary* (n 90) 123; Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 468-469.

<sup>150</sup> See n 139.

<sup>151</sup> P Riis, 'Discussion' following the chapter by Armstrong, 'Transvestism' (n 49) 91; Benjamin, *The Transsexual Phenomenon* (n 49) 48.

<sup>152</sup> Hamburger, Sturup and Dahl-Iversen, 'Transvestism; Hormonal, Psychiatric, and Surgical Treatment' (n 43) 392; AH Esman, 'A Case of Self-Castration' (1954) 120 *Journal of Nervous and Mental Disease* 79 (self-castration with a razor; patient wanted to be a girl); SE Cleveland, 'Three Cases of Self-Castration' (1956) 123 *Journal of Nervous & Mental Disease* 386 (first patient wanted to be a girl; third attempt successful using self-constructed clamp to prevent bleeding);

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occur and are described in the literature. In a review of 100 MTF cases in 1965,

Pauly found that 18 had attempted castration, with 9 succeeding.<sup>153</sup> In *The*

*Transsexual Phenomenon*, Benjamin commented:

Sometimes these acts of self-mutilation are done in desperation. Others are more deliberate and are meant to force the surgeon's hand to complete the genital alteration which he had refused to undertake for reasons of his ethical concepts, or for lack of hospital facilities (where the necessary permission was withheld by the hospital board), for fear of criticism or out of consideration of existing laws.<sup>154</sup>

American judges used the risks of suicide and self-harm to support a patient-focused public policy justification. In the 1977 Georgia case *Rush v. Parham*, the patient challenged the state's denial of funding for GRS from their medicaid plan (for those with a low income). The trial court endorsed the evidence of the patient's psychiatrist on a motion for summary judgment:

The diagnosis in this case is definitely that of transsexualism. She has made a mature decision in regard to sex reassignment surgery. I feel that such surgery is urgently indicated because of the feelings of despair and frustration which she has had in regard to her condition. There is no approach other than surgery which can alleviate her depression and remove the threat of suicide.<sup>155</sup>

Although the appeal court returned the trial court's decision in favour of the patient for a full hearing, the California Court of Appeals subsequently cited this

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KH Blacker and N Wong, 'Four Cases of Autocastration' (1963) 8 *Archives of General Psychiatry* 169; Walker and Fletcher, *Sex and Society* (n 48) 199 (transsexual attacked a testicle with a scissors, resulting in a need for surgical castration due to the irreparable damage to the testicle); DP van Kammen and J Money, 'Erotic Imagery and Self-Castration in Transvestism/Transsexualism' (1977) 2 *Journal of Homosexuality* 359, 360-361 (use of a farm castration tool); D Green, 'Legal Aspects of Transsexualism' (1971) 1 *Archives of Sexual Behavior* 145, 148 (patient asked a prostitute to remove his sex organs with a razor); E de Savitsch, *Homosexuality, Transvestism, and Change of Sex* (William Heinemann Medical Books Ltd. 1958) 51, 55-56, 73, 80, 83 (removal of penis with an axe; use of a string as a tourniquet); Benjamin, 'Transvestism and Transsexualism' (n 63) 13; Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 467. Meyerowitz describes two cases of self-castration, one in which the patient "almost bled to death" (Caren Ecker, discussed at n 139, and another which was successful, the patient having "studied the surgical procedure step by step and memorized its sequence" beforehand. Meyerowitz, *How Sex Changed* (n 38) 145-146.

<sup>153</sup> IB Pauly, 'Male Psychosexual Inversion: Transsexualism: A Review of 100 Cases' (1965) 13 *Archives of General Psychiatry* 172, 177.

<sup>154</sup> Benjamin, *The Transsexual Phenomenon* (n 49) 47-48.

<sup>155</sup> *Rush v Parham* 440 FSupp 383, 386 (1977, ND Ga), reversed by *Rush v Parham* 625 F2d 1150 (1980, 5th Cir).

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quotation with approval in a similar 1978 case. In *G.B. v. Lackner*, the patient sought funding for GRS from the state medicaid program for those with a low income (Medi-Cal).<sup>156</sup> The patient's expert psychologist and her treating physician also mentioned the risks of suicide and self-harm.<sup>157</sup>

Legal and medical commentators in the US,<sup>158</sup> UK,<sup>159</sup> Canada<sup>160</sup> and beyond<sup>161</sup> also used the risks of suicide and self-harm. David Meyers described a consensus that these "wider, rather atypical therapeutic grounds" were *sufficient* to provide a patient-focused public policy justification.<sup>162</sup> The leading British medical law academic Ian Kennedy went further, arguing that the risk of self-harm by the patient was a *necessary* condition of legality; GRS would only be lawful if expert medical opinion could demonstrate "at least some risk of harm to the patient if surgery is not performed."<sup>163</sup> John Randell, the surgeon who carried out many

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<sup>156</sup> *GB v Lackner* 80 Cal App 3d 64, 67-68 (1978).

<sup>157</sup> *ibid* 67, 68.

<sup>158</sup> H Guze, 'The Transsexual Patient: A Problem in Self-Perception' (1967) 29 Transactions of the New York Academy of Sciences 464, 466; Money and Schwartz, 'Public Opinion and Social Issues in Transsexualism' (n 49) 267-268 which reproduces the Press Release of 21 November 1966 entitled "On the establishment of a clinic for transsexuals at the Johns Hopkins Medical Institutions". The Press Release quoted Dr. John E. Hoopes, chairman of the Gender Identity Clinic: "The high incidence of suicide and self-mutilation among these people testifies to the magnitude of the problem. If the mind cannot be changed to fit the body, then perhaps we should consider changing the body to fit the mind." This quotation appeared in *GB v Lackner* (n 156) 68. The establishment of the Gender Identity Clinic at Johns Hopkins is discussed in the text accompanying nn 192-195.

<sup>159</sup> Meyers, 'Problems of Sex Determination and Alteration' (n 49) 174, 185-186; Meyers, *The Human Body and the Law* (n 68) 66-67; King, *The Transvestite and the Transsexual* (n 93) 54-55.

<sup>160</sup> Edwards, 'Recent Developments Concerning the Criteria of Sex and Possible Legal Implications' (n 65) 126; Moore and Edwards, 'Medico-Legal Aspects of Intersexuality: Criteria of Sex: Part II' (n 65) 759. Approved by Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 65, 72-73. Meyers subsequently based the entirety of his analysis of the legality of GRS in Canada on Edwards' views. Meyers, 'Problems of Sex Determination and Alteration' (n 49) 181; Meyers, *The Human Body and the Law* (n 68) 59-60. See also, Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (n 13) 985.

<sup>161</sup> SA Strauss, 'The Sex Change Operation: Two Interesting Decisions' (1967) 84 South African LJ 214, 216; Hamburger, Sturup and Dahl-Iversen, 'Transvestism; Hormonal, Psychiatric, and Surgical Treatment' (n 43) 392; de Savitsch, *Homosexuality, Transvestism, and Change of Sex* (n 152) 51, 70, 71, 76.

<sup>162</sup> Meyers, *The Human Body and the Law* (n 68) 66-67. Meyers had made a similar claim two years earlier in 1968: 'Problems of Sex Determination and Alteration' (n 49) 185.

<sup>163</sup> IM Kennedy, 'Transsexualism and Single Sex Marriage' (1973) 2 Anglo-American L Rev 112, 117-118.



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gender reassignment procedures at Charing Cross Hospital in London had received legal advice to this effect:

I have been advised by a solicitor of one of the defense organizations that it is not enough to operate on a patient to make it more comfortable for him to live in the world in the female gender role, or *vice versa*. There must be some medical indication, as in the case of the proposed abortion, preferably signed by two psychiatrists, to the effect that this operation is necessary *to preserve the mental health and to prevent deterioration to a serious degree of the mental stability of the patient in question*. And I think that one can say this of a large number of our patients.<sup>164</sup>

In one New York case, the court also used the absence of a risk of suicide or self-harm to determine that GRS was not medically necessary—although the legality of GRS was not directly in issue. In *Denise R. v. Lavine*, the state court upheld an administrative decision denying funding for GRS to a patient on the grounds that “there was no disturbance in thinking or suicidal inclination”.<sup>165</sup>

#### Professionally-focused public policy justification

Most commentators described the absence of a professional consensus needed to support a professionally-focused public policy justification.<sup>166</sup> In 1973, the US Department of Health Education and Welfare concluded that:

Transsexualism has not at this time reached the status of a *generally accepted*, clearly defined diagnostic entity. Even if such an entity could be established, reconstructive surgery (to make body changes in keeping with gender of choice) has not reached the status of a

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<sup>164</sup> Randell, 'Indications for Sex Reassignment Surgery' (n 131) 160 [emphasis added]. This legal advice was based on the abortion case *Bourne* [1939] 1 KB 687 (Central Criminal Court).

<sup>165</sup> *Denise R v Lavine* 39 NY2d 279, 282-283 (1976, CA). This was the view of one medical expert, which had been preferred over the evidence of another expert who had testified that the procedure “was a matter of life and death”.

<sup>166</sup> See text accompanying n 43, and see also, R Green, RJ Stoller and C MacAndrew, 'Attitudes toward Sex Transformation Procedures' (1966) 15 Archives of General Psychiatry 178, 178-182; Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 466-467; James, 'Legal Issues of Transsexualism in England' (n 29) 449; Meyers, *The Human Body and the Law* (n 68) 67; Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (n 13) 973, 974; PJ Thomas, 'Can the Lawyer Keep up with the Doctor?' (1980) 97 South African LJ 77, 80; Randell, 'Indications for Sex Reassignment Surgery' (n 131) 154.

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*professionally accepted or recognized* modality of treatment to be routinely utilized, although such surgery is provided at a number of medical centers on a research basis.<sup>167</sup>

As late as 1983, the US District Court held in *Rush v. Johnson* that "[t]he evidence demonstrates that [GRS] is neither generally accepted [by the professional medical community] as a proven and effective treatment nor is there authoritative evidence that the surgery is safe and effective."<sup>168</sup> Historians including King, Meyerowitz, Reis and Rudacille have agreed that no professional consensus existed.<sup>169</sup>

Despite its role in the development of a patient-focused public policy justification, even the risk of suicide and self-harm failed to create a professional consensus.<sup>170</sup> "Many physicians preferred to see the patient in extremis rather than permit treatment."<sup>171</sup> In their survey of the attitudes of US physicians, Richard Green, Robert J. Stoller, and Craig MacAndrew noted that a majority of respondents felt that a patient's "almost certain[] suicide should sex reassignment be denied ... should not influence their decision opposing sex reassignment."<sup>172</sup> Thus the public policy justification was not professionally-focused. The absence of professional consensus had overlapping explanations,

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<sup>167</sup> US Department of Health Education and Welfare decision, communicated in a personal letter dated September 1973, from an associate regional commissioner for Region I (centered in Boston) to the associate commissioner of the Division of Vocational Rehabilitation, quoted in ES David, 'The Law and Transsexualism' (1975) 7 Connecticut L Rev 288, 333-334 [emphasis added].

<sup>168</sup> *Rush v Johnson* 565 FSupp 856, 868 (1983, Dist Ct, ND Ga, Atlanta Division).

<sup>169</sup> King, *The Transvestite and the Transsexual* (n 93) 54; Meyerowitz, *How Sex Changed* (n 38) 273; Reis, *Bodies in Doubt* (n 135) 145; Rudacille, *The Riddle of Gender* (n 78) 123-140.

<sup>170</sup> Although at least one commentator considered it to be a future possibility. Meyers, *The Human Body and the Law* (n 68) 54.

<sup>171</sup> E Crovitz, 'Treatment of the Transsexual and Medicolegal Issues' (1976) 7 Forensic Science 1, 4.

<sup>172</sup> Green, Stoller and MacAndrew, 'Attitudes toward Sex Transformation Procedures' (n 166) 180 ("The probability of the patient's suicide should his request be denied raised the percentages of physicians approving the request only slightly; the majority of psychiatrists, 54%, felt that this should not in any way influence the decision."); Green, 'Attitudes toward Transsexualism and Sex-Reassignment Procedures' (n 49) 238.

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including professional distaste for moral<sup>173</sup> or religious<sup>174</sup> reasons, and doubts about the legality of procedures including castration.

### Public-focused public policy justification

Given the public controversy over early cases,<sup>175</sup> it is unsurprising that few doctors or lawyers tried to find a public-focused public policy justification for GRS. The medical profession avoided public attention and debate for the reasons already mentioned, including their doubts about legality and professional distaste. There was no third-party beneficiary or obvious societal benefit of the controversial procedures. Commentators generally avoided this form of justification, and the few attempts to use it were unconvincing. For example, Thomas James wondered whether "perhaps an overriding social necessity" might be found in some GRS cases, "as in the case of castration of the so-called sexual psychopath ..., sexual deviants, and morons".<sup>176</sup> One could also infer a rejection of the public-focused public policy justification in the writings of those who argued that the legitimization of these surgical procedures would harm society:

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<sup>173</sup> "Those involved were aware that their work in this area was regarded with some distaste by their fellow professionals who in the words of one surgeon, 'thought we were just dealing with homosexuals and perverts'". King, *The Transvestite and the Transsexual* (n 93) 53. See also, Bishop (n 49) 90; Meyers, 'Problems of Sex Determination and Alteration' (n 49) 186; Meyerowitz, 'Sex Research at the Borders of Gender' (n 63) 85.

<sup>174</sup> Gillies and Millard, *The Principles and Art of Plastic Surgery* (n 87) 371; Benjamin, *The Transsexual Phenomenon* (n 49) 142; Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 467; Crovitz, 'Treatment of the Transsexual and Medicolegal Issues' (n 171) 4. In William O'Connell's account of his experience in an unnamed American hospital in the 1960s, he described the refusal of the hospital's Tissue Committee to approve his surgery in order to placate "the religious elements" within the hospital. WJ O'Connell, 'The Unfree' in H Benjamin (ed), *The Transsexual Phenomenon* (Julian Press 1966) 54.

<sup>175</sup> See, eg, Meyerowitz, 'Sex Change and the Popular Press' (n 102); Kennedy, *The First Man-Made Man* (n 90); Hodgkinson, *Michael, Née Laura* (n 89).

<sup>176</sup> James, 'Legal Issues of Transsexualism in England' (n 29) 449. This was a softening of his position on *Cowburn*, quoted in the text accompanying nn 28-29.

It is one thing to make life in society easier for those who exhibit the intersex conditions of Hermaphroditism or Pseudo-hermaphroditism, and quite another to leave a possible loophole for those suffering from sexual aberrations or deviations, such as certain trans-sexuals, who may have the strongest motives or drives to pass, legally or illegally, from one side of the sexual spectrum to, the other, and who, In the event of success In achieving the social sex of their desire, might bring disastrous consequences not only upon themselves but upon other [sic] in the society in which they live.<sup>177</sup>

### **The shift towards legality**

A period of legal uncertainty followed on from the earlier consensus that GRS was unlawful. During this period professional confidence in the lawfulness of GRS grew as clinicians used the tactics previously outlined to bring GRS within the patient-focused public policy justification. The legal implications of changing gender brought the law into contact with patients who had already undergone GRS, opening the door to indirect judgments of its lawfulness.

### **Consensus that GRS unlawful**

Until the early 1960s, the medical and legal professions and even the wider public regarded GRS—including but not limited to castration—as unlawful. Robert Veit Sherwin noted “the popular conception that everything connected with this subject is illegal in this country [the USA].”<sup>178</sup> Demand for GRS was low<sup>179</sup> and there was considerable reluctance to undertake it.<sup>180</sup> Those doctors who were involved in GRS made extensive efforts to keep the procedures quiet

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<sup>177</sup> *Forbes-Sempill* (n 136) 18. For a more modern version of this argument, see Twardy, 'Medicolegal Aspects of Transsexualism' (n 22) 295.

<sup>178</sup> Sherwin, 'The Legal Problem in Transvestism' (n 68) 243.

<sup>179</sup> Benjamin, 'Transsexualism and Transvestism as Psychosomatic and Somatopsychic Syndromes' (n 63) 229. Benjamin observed that “[a] conversion-operation is an infrequent procedure, even allowing for the fact that it may often be kept a deep secret (as a supposedly illegal procedure).” See also, Meyers, 'Problems of Sex Determination and Alteration' (n 49) 176, and the description by Hedy Jo Star in the text accompanying n 114.

<sup>180</sup> MM Belli, 'Transsexual Surgery: A New Tort?' (1978) 239 JAMA 2143.

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and themselves relatively anonymous,<sup>181</sup> at least in part because of the fear of legal repercussions. In the United Kingdom, "those who continued to operate on transvestites (some discontinued their involvement) felt themselves to be 'tainted' by this involvement operating surreptitiously or at least without publicity or professional report".<sup>182</sup> Stryker observes that "In the 1950s, only a few dozen "sex change" operations were performed in the United States, most of them by Los Angeles urologist Elmer Belt (a friend of Benjamin's), *under conditions of secrecy*."<sup>183</sup>

The need for legal intervention to change the patient's gender status after the surgical procedures had taken place increased the risk of exposure. This prevented GRS from remaining completely within the private sphere. The isolation caused by low demand and secrecy, coupled with the risk of exposure increased the fear of prosecution.

Most scholars agree that the doubts about the legality of GRS had a significant impact on medical practice. In the American context, Deborah Rudacille argues that "[i]n the fifties and early sixties, mayhem statutes were the single greatest obstacle faced by every transsexual person in America unable to travel overseas for surgery or locate one of the few surgeons willing to flout the law by performing surgery in the United States."<sup>184</sup> Susan Stryker agrees that the fear of prosecution played a significant role in professional reluctance to perform surgery, placing particular emphasis on "California Attorney General Pat Brown's

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<sup>181</sup> In the United Kingdom, see the discussion of the procedures Gillies undertook for Cowell after the orchidectomy in Pound, *Gillies, Surgeon Extraordinary* (n 90) 204.

<sup>182</sup> King, *The Transvestite and the Transsexual* (n 93) 53.

<sup>183</sup> Stryker, *Transgender History* (n 113) 45 [emphasis added].

<sup>184</sup> Rudacille, *The Riddle of Gender* (n 78) 115.

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legal opinion against genital modification [which] created legal exposure for doctors who performed genital surgery."<sup>185</sup>

Joanne Meyerowitz dissents, downplaying the effect of doubts about lawfulness:

legality and the ethics of removing healthy organs were not the sole or even the primary obstacles to sex-change surgery. The few American doctors who occasionally performed surgery on transsexuals suffered no legal penalty. No one was prosecuted for sex-change surgery under the mayhem statutes or any other laws.<sup>186</sup>

However, Meyerowitz's analysis underestimates the impact of the *threat* of prosecution. The *prima facie* applicability of the criminal offence of maim or mayhem to castration (despite Sherwin's argument to the contrary) undoubtedly gave the threat of prosecution substance, as did the involvement of leading prosecutors. As we have seen, the threat of prosecution inhibited doctors from proceeding,<sup>187</sup> and even affected the kinds of procedures performed.<sup>188</sup> The little empirical evidence that exists bears out this effect. A survey of psychiatrists undertaken in the mid-1960s revealed that "64 percent [of 168 psychiatrists] were concerned over the legal implications" of GRS.<sup>189</sup>

#### A period of legal uncertainty

Surgeons began offering GRS at specialist clinics in Minnesota (at the University of Minnesota) and Maryland (at Johns Hopkins) in 1966.<sup>190</sup> For different reasons,

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<sup>185</sup> Stryker, *Transgender History* (n 113) 73.

<sup>186</sup> Meyerowitz, *How Sex Changed* (n 38) 121. See also, JC Finney, 'Transsexuality and the Laws on Sexual Mores' in DR Laub and P Gandy (eds), *Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome* (Division of Reconstructive and Rehabilitation Surgery, Stanford University Medical Center 1974).

<sup>187</sup> See n 49 and accompanying text.

<sup>188</sup> See text accompanying nn 116-119.

<sup>189</sup> R Green, 'Physician Emotionalism in the Treatment of the Transsexual' (1967) 29 *Transactions of the New York Academy of Sciences* 440, 441. See also, Green, Stoller and MacAndrew, 'Attitudes toward Sex Transformation Procedures' (n 172).

<sup>190</sup> Tierney and O'Brien, 'You're a Good Man Charlotte Brown or What Now My Love?' (n 49) 4. On Johns Hopkins, see the Press Release of 21 November 1966 (n 158), and T Buckley, 'A

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the threat of prosecution was attenuated in both Minnesota and Baltimore (where Johns Hopkins is located). By 1966, Minnesota no longer had a mayhem statute. This "absence ... was regarded as pivotal by the attorneys who studied the matter" and provided advice to the psychiatrists seeking to provide GRS to an MTF transsexual patient.<sup>191</sup>

Maryland did have a mayhem statute; indeed fear of prosecution for mayhem had caused the doctors at Johns Hopkins to refuse to operate on Hedy Jo Star in 1959.<sup>192</sup> However, five years later an unusual case in Baltimore had reassured those doctors. G.L., a teenage boy with a history of arrests for stealing items of female clothing and accessories had been diagnosed as a transsexual during the psychiatric examinations conducted within the forensic process. He had requested GRS in 1964. Based on the recommendation of the psychiatrists and G.L.'s probation officer, the juvenile court judge issued a court order authorizing the surgery:

When the case of G.L. arose, the specialists involved in the case, confident of the strength and accuracy of the medical decision about sex reassignment for G.L., did not embark upon the procedure of asking the law what should be done. Rather, events proceeded in such a way that the probation officer, the judge, and the two specialists at The Johns Hopkins Hospital coalesced their efforts to form a liaison between medicine and the law in the event that elective surgical conversion should be challenged in the future. The judge signed a court order for the surgical procedure. This court order would set no precedent unless challenged by a higher court. Nevertheless, the very act of signing a court order placed the procedure within the purview of the law.<sup>193</sup>

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Changing of Sex by Surgery Begins at Johns Hopkins' *New York Times* (21 November 1966) 1, 32. It was an approach by Buckley that prompted the Johns Hopkins clinic to prepare the Press Release. Money and Schwartz, 'Public Opinion and Social Issues in Transsexualism' (n 49) 256.

<sup>191</sup> A detailed account of the early Minnesota experience is found in Hastings, 'Inauguration of a Research Project on Transsexualism in a University Medical Center' (n 49).

<sup>192</sup> See text accompanying n 115.

<sup>193</sup> Money and Schwartz, 'Public Opinion and Social Issues in Transsexualism' (n 49) 258.

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Although the doctors did not perform the procedure, the Hopkins group and their colleagues across the country saw the existence of the court order as significant.<sup>194</sup> Pauly described this court order as having "protected the physicians and hospitals involved against legal consequences. This ruling permitted the foundation of the Gender Identity Committee at the Johns Hopkins Hospital."<sup>195</sup>

The persistence over time of the chilling effect associated with this period of legal uncertainty is disputed. Joanne Meyerowitz claims that by the late 1960s, "doctors and lawyers had ceased using the mayhem statutes as an excuse to refuse sex reassignment surgery."<sup>196</sup> Certainly by 1971, Harry Benjamin—who was involved in many American cases—was apparently satisfied that there were no legal impediments, and discussed the issue assuming that the procedure was entirely lawful.<sup>197</sup> In the same year the leading British surgeon John Randell complained that "the law on this is not clear, neither is it going to be clear, to some extent, after tomorrow. It is almost dangerous for us to undertake surgery in these cases." He nevertheless continued to carry out selected procedures.<sup>198</sup> Robert Kouri reported that the chilling effect of mayhem statutes continued into the 1970s,<sup>199</sup> and this assessment is consistent with the work of Janice Raymond

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<sup>194</sup> One of the Hopkins group, John Money, was interviewed by Buckley for his 1966 article in the *New York Times* (n 190) in which Buckley wrote that "Experts in the field believe that the Johns Hopkins decision that the surgery does not violate legal restrictions on mutilation or ethical or moral codes will lead to its being performed at other hospitals in the United States."

<sup>195</sup> Pauly, 'The Current Status of the Change of Sex Operation' (n 43) 468.

<sup>196</sup> Meyerowitz, 'Sex Change and the Popular Press' (n 102) 184, n 69. See also, the response of the California Attorney General Mosk (n 112).

<sup>197</sup> H Benjamin, 'Should Surgery Be Performed on Transsexuals?' (1971) 25 *American Journal of Psychotherapy* 74. See also, H Benjamin and CL Ihlenfeld, 'Transsexualism' (1973) 73 *The American Journal of Nursing* 457 (also assuming the legality of surgery including orchidectomy).

<sup>198</sup> Randell, 'Indications for Sex Reassignment Surgery' (n 131) 154.

<sup>199</sup> Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 73.



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and Susan Stryker.<sup>200</sup> For a few scholars, the threat of prosecution lingered long after it had ceased to be felt by surgeons.<sup>201</sup>

Nonetheless, the strategies previously outlined to bring GRS within the patient-focused public policy justification by manipulating diagnoses, expanding the role of after-care, and focusing on the risk of harm to the patient if GRS were not provided gave a few surgeons sufficient confidence to proceed. Both the growing number of procedures,<sup>202</sup> and undoubtedly the absence of actual prosecutions<sup>203</sup> helped to rebut legal doubts. The number of GRS performed in the US and UK slowly built up in the late 1960s, of which after-care cases including cases of repair of actual self-harm formed a substantial part.<sup>204</sup> A small number of specialised clinics in the US and the UK gradually began to offer GRS to rigorously selected patients.<sup>205</sup>

During the 1970s, inferences drawn from legislative, governmental and judicial decisions amplified this growing professional confidence in the lawfulness of GRS on the basis of the narrowly interpreted patient-focused public policy justification.

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<sup>200</sup> See text accompanying nn 110-113.

<sup>201</sup> The federal prosecutor Stan Twardy was still arguing in 1980 that "surgeons, performing sex change operations, could be prosecuted under existing statutes of mayhem, simple and aggravated battery, criminal negligence, murder, conspiracy, suicide (where it is still a crime), and some other laws." Twardy, 'Medicolegal Aspects of Transsexualism' (n 22) 295. Relatively recent scholarship in Ireland and Queensland suggests that the patient-focused public policy justification cannot be stretched to include such operations: D Tomkin and P Hanafin, *Irish Medical Law* (Round Hall Press 1995) 109; RS O'Regan, 'Surgery and Criminal Responsibility under the Queensland Criminal Code' (1990) 14 Criminal LJ 73, 75.

<sup>202</sup> For example in *Corbett v Corbett* (n 17) 98, Ormrod J noted that "Dr. Randell [at Charing Cross Hospital] has recommended surgical treatment in about 35 cases mostly restricted to castration and amputation of the penis". Randell appeared as an expert witness in *Corbett v Corbett*.

<sup>203</sup> Meyerowitz, *How Sex Changed* (n 38) 121.

<sup>204</sup> DR Laub and N Fisk, 'A Rehabilitation Program for Gender Dysphoria Syndrome by Surgical Sex Change' (1974) 53 Plastic and Reconstructive Surgery 388, 398.

<sup>205</sup> Tierney and O'Brien, 'You're a Good Man Charlotte Brown or What Now My Love?' (n 49) 4; Meyerowitz, *How Sex Changed* (n 38) 126-129; M Mehl, 'Transsexualism: A Perspective' in DR Laub and P Gandy (eds), *Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome* (Division of Reconstructive and Rehabilitation Surgery, Stanford Univ. Medical Center 1974).

Inferring lawfulness

Formal legal change—judicial decisions or legislation—on GRS was rare in common law jurisdictions.<sup>206</sup> The culture of secrecy and anonymity made prosecution unlikely unless those involved chose to invite it. Although doctors and lawyers anticipated test cases in both the UK<sup>207</sup> and the US,<sup>208</sup> they did not occur. The fear was not only of prosecution itself;<sup>209</sup> campaigners also worried that a negative decision would set a precedent for future cases.<sup>210</sup> The courts could not be avoided entirely though, as patients needed to change their gender status after GRS, and to resolve legal complications in relation to marriage, children and inheritance. The high cost of GRS also led some patients towards the courts to challenge administrative decisions not to provide funding for it.

Legislation explicitly permitting GRS also failed to materialise, likely due to low demand and legislators' desire to avoid "dealing with sexual matters".<sup>211</sup> Legislators and governments were more comfortable dealing with the issue of GRS more obliquely, by addressing the legal implications of the surgery after it was performed, or the issue of funding.

From such judicial, administrative and legislative decisions, the inference could be drawn that GRS must be lawful. The strength of the inference would depend on the reach of the legislation, administrative or judicial decision. A very strong inference of legality could be drawn from national legislation providing funding

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<sup>206</sup> For examples involving other new and controversial medical procedures, see Lewis, 'The Medical Exception' (n 9) 364. An example of formal legal change on GRS is found in the Spanish Criminal Code: "valid free, conscious and specifically expressed consent shall exempt from criminal accountability in cases of ... transsexual surgery carried out by a surgeon ..." Criminal Code 1995, art 156.

<sup>207</sup> Meyers, 'Problems of Sex Determination and Alteration' (n 49) 176.

<sup>208</sup> Money and Schwartz, 'Public Opinion and Social Issues in Transsexualism' (n 49) 259.

<sup>209</sup> Rudacille, *The Riddle of Gender* (n 78) 116.

<sup>210</sup> Stoller, 'A Biased View of 'Sex Transformation' Operations' (n 112) 314.

<sup>211</sup> Meyers, 'Problems of Sex Determination and Alteration' (n 49) 176.

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for the procedure,<sup>212</sup> or permitting birth certificates to be changed.<sup>213</sup> The pattern found in the United States, Canada and (to a lesser extent) the United Kingdom, was of judicial decisions of lesser reach, and legislation or administrative decisions at a state or provincial rather than national or federal level. The inferences which could be drawn were less strong, but as they accumulated, doubts about legality receded.

In many US states and Canadian provinces, one of the main indications of legality was the decision to permit birth certificates to be altered following GRS. If the legality of GRS was subsequently questioned during judicial proceedings, the public policy justification could then be judicially interpreted in light of the relevant governmental or legislative decision to authorise this change of legal status, most obviously by using the public-focused public policy justification.<sup>214</sup> A rare example of early judicial recognition of such an inference is found in *City of Chicago v. Wilson*, in which the Illinois Supreme Court held that a local ordinance prohibiting a person from wearing clothing of the opposite sex with intent to conceal the wearer's sex constituted an unconstitutional interference with the defendants' liberty interests. The majority reasoned that:

[t]hrough the enactment of section 17(1)(d) of the Vital Records Act ..., which authorizes the issuance of a new certificate of birth following sex-reassignment surgery, the [state] legislature has implicitly recognized the necessity and validity of such surgery.<sup>215</sup>

In the language of the public-focused public policy justification, as the legislature had decided to issue new birth certificates to post-operative transsexuals, the

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<sup>212</sup> As was the case in for contraceptive sterilisation after the passage of the National Health Service (Family Planning) Amendment Act 1972. See P Lewis, 'Legal Change on Contraceptive Sterilisation' (2011) 32 *Journal of Legal History* 295.

<sup>213</sup> See, eg, Skegg, Paterson and Manning, *Medical Law in New Zealand* (n 27) [5.3.4(2)].

<sup>214</sup> See, eg, *ibid.*

<sup>215</sup> *City of Chicago v Wilson* 369 NE2d 522, 533-534 (1978, Ill SC).

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judge could infer that there was "just cause" for GRS, or that it was undertaken for a "lawful purpose".<sup>216</sup> Commentators also drew such inferences. In an internationally influential 1971 US law review article,<sup>217</sup> Douglas K. Smith argued that "it is very unlikely that these states' legislatures would enact such a provision if they considered the surgery itself illegal."<sup>218</sup>

Alternatively, legality could be inferred from legislative or governmental decisions to provide state funding for some or all patients. Smith drew this inference from the British government's decision to fund GRS: "An administrative decision favoring the legality of [gender reassignment] surgery apparently has been made, since the operation may now be paid for by Britain's National Health Insurance plan."<sup>219</sup> In fact the funding of GRS in the UK was much less formally clear than Smith suggested, although GRS was informally available on the National Health Service in the 1970s.<sup>220</sup>

Another possibility was to infer legality from the decisions of judicial or professional regulatory bodies where GRS formed part of the factual background but its lawfulness was not directly in issue. The most common illustration of this type of inference is the civil, public or administrative law claim in which the

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<sup>216</sup> Skegg, Paterson and Manning, *Medical Law in New Zealand* (n 27) [5.3.4(2)]. The Illinois state legislature was the first state to permit such changes. See Tierney and O'Brien, 'You're a Good Man Charlotte Brown or What Now My Love?' (n 49) 5.

<sup>217</sup> See, eg, Thomas, 'Can the Lawyer Keep up with the Doctor?' (n 166) 79-81 (South Africa); David, 'The Law and Transsexualism' (n 167) 294-295; Kennedy, 'Transsexualism and Single Sex Marriage' (n 163) 114 (UK); Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 75-77 (Canada); CS Presser, 'Legal Problems Attendant to Sex Reassignment Surgery' (1977) 5 *Journal of Legal Medicine* (NY) 17, 20.

<sup>218</sup> Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (n 13) 988 (noting that Louisiana and Illinois then permitted such changes of birth records). Kouri applied Smith's reasoning to the Canadian context. Kouri, *Certain Legal Aspects of Modern Medicine* (n 33) 69-70, observing that three US states (including Arizona) and two Canadian provinces (Alberta and British Columbia) then permitted birth certificates to be changed.

<sup>219</sup> Smith, 'Transsexualism, Sex Reassignment Surgery and the Law' (n 13) 986.

<sup>220</sup> King, *The Transvestite and the Transsexual* (n 93) 62. See also, M Roth, 'Transsexualism and the Sex-Change Operation: A Contemporary Medico-Legal and Social Problem' (1981) 49 *The Medico-Legal Journal* 5. One such example is found in *Rees v United Kingdom* (1987) 9 EHRR 56 (ECHR) (describing FTM GRS carried out on the NHS in 1974).

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underlying legality of the procedure is assumed or (more rarely) directly addressed. An example of the latter occurred during the 1970 marriage nullification proceedings in *Corbett v. Corbett*, in which the trial judge used a broad patient-focused public policy justification for GRS.<sup>221</sup> Such an assumption also underlies the 1978 California case *G.B. v. Lackner*, in which the court held that GRS for an MTF transsexual could not be considered "cosmetic surgery" and thereby excluded from the state medicaid program for those with a low income (Medi-Cal), using a narrow patient-focused public policy justification reliant on the risks of suicide and self-harm.<sup>222</sup>

As legislative and judicial decisions from which the legality of GRS could be inferred multiplied, the doubts about legality receded. Thus the need for legal intervention to change the patient's gender status after GRS had both a negative and positive impact. By increasing the risk of exposure it discouraged the medical profession from performing GRS. But as legislatures and courts gradually permitted such changes of status, the inference that GRS was lawful was strengthened. To a lesser extent, the high cost of GRS<sup>223</sup> also increased the impetus for patients to seek review of funding decisions through recourse to the

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<sup>221</sup> *Corbett v Corbett* (n 17) 99, discussed in the text accompanying n 20. Subsequent judicial review applications challenging funding refusals in England and Wales have assumed the lawfulness of GRS. *North-West Lancashire Health Authority v A, D and G* [2000] FCR 525 (CA) (judicial review of a local policy not to fund GRS); *AC v Berkshire West Primary Care Trust* [2011] EWCA Civ 247 (judicial review of a refusal of funding for breast augmentation for an MTF transsexual).

<sup>222</sup> *GB v Lackner* (n 156 and accompanying text). See also, *Doe v State* (n 18) (funding should be provided if GRS medically necessary), and in the private sector, *Davidson v Aetna Life & Cas. Ins. Co* 420 NYS2d 450 (1979, N.Y. Supreme Court). For a contrary view, see *Rush v Parham* (n 155 and accompanying text); *Casillas v Daines* 580 FSupp 2d 235 (2008, SD NY). For an overview of all of the relevant federal and state cases, see JM Zitter, 'Gender Reassignment or "Sex Change" Surgery as Covered Procedure under State Medical Assistance Program' (2010) 60 ALR6th 627 (last updated 17 May 2015).

<sup>223</sup> King, *The Transvestite and the Transsexual* (n 93) 50; Hausman, *Changing Sex* (n 42) 172.

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courts or legal authorities, and inferences of legality could even be drawn when claims for funding were unsuccessful.<sup>224</sup>

### **Conclusion: The role of the law**

The period of legal uncertainty undoubtedly increased the suffering of patients and potential patients. The reasons behind the unavailability of the public- and professionally-focused public policy justifications contributed to a narrow interpretation of the patient-focused public policy justification using the well-established risks of suicide and self-harm to support a characterisation of the procedures as having a net benefit only for those patients at such risk. This approach may itself have increased the risk of self-harm amongst the patient population, particularly as they came to hear about cases of after-care provided following self-harm.

The hoped-for alternative, more effective, less invasive procedures<sup>225</sup> did not materialise during the period of legal uncertainty (or indeed in the years since). The criminal law had played both an important and primarily malign role prior to the eventual public, professional and legal acceptance of GRS.

The role played by inferences of legality drawn from related civil law decisions which bolstered the legal acceptance of gender reassignment surgery has been under-explored. These inferences were consistent with public-focussed public policy justifications for GRS, which were not restricted in the way that the patient-focused public policy justification had been interpreted. Civil and

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<sup>224</sup> See, eg, *Rush v Parham* discussed in the text accompanying n 155.

<sup>225</sup> See, eg, Meyers, 'Problems of Sex Determination and Alteration' (n 49) 186 ("Eventually, hopefully, the transsexual's torment can be attacked and solved where it originates—deep in his psyche."); Laub and Fisk, 'A Rehabilitation Program for Gender Dysphoria Syndrome by Surgical Sex Change' (n 204) 391.

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administrative law played a more positive albeit indirect role in interpreting the medical exception and its application to gender reassignment surgery.

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